Report of the
Urology Services Inquiry

Inquiry Website: www.urologyservicesinquiry.org.uk

Christine Smith CBE KC and Dr Sonia Swart MD FRCP FRCPath assert their right to be identified as the sole authors of this work, in accordance with section 78 of the Copyrights, Designs and Patents Act 1988. They wish to acknowledge the contribution of the Inquiry's Assessor, Mr Damian C Hanbury MS FRCS (Urol) to the work of the Inquiry and his assistance to the authors of this work.

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Knowledge and investigation of concerns prior to May 2020

Introduction

1. This chapter considers the Trust's implementation of the Maintaining High Professional Standards Framework[1] (MHPS) in its investigation concerning Mr O'Brien's practice and examines the Trust's handling of relevant complaints and concerns which had been identified prior to May 2020 in seeking to answer the fundamental question of whether there were any concerns or circumstances which should have prompted the Trust to instigate an earlier and more thorough investigation. Through so doing, it addresses paragraphs (a) and (e) of the Inquiry's Terms of Reference (ToR).

2. Part (e) of the Inquiry's ToR draws attention to a specific instrument which was available to the Trust for addressing concerns relating to the practice of Mr O'Brien, that is, the MHPS policy or framework. As our consideration of Part (a) will make clear, MHPS was not the only process available to the Trust when it became concerned about Mr O'Brien's performance, and the efficacy of those other processes will be examined. However, by necessity, our focus when considering the issues described by ToR (e) will be the formal MHPS exercise which was initiated by the Trust in 2016 and which concluded in late 2018. We will consider the evidence gathered by the Inquiry and determine whether the MHPS framework was well used in this specific case. More generally, we will assess whether the policy itself can be considered fit for purpose or whether reform is required.

3. There are three constituent parts to ToR (e), namely:

    i. Reviewing the implementation of MHPS with regard to Mr O'Brien. This involved an examination of the actions of the Trust leading to a decision to initiate a formal MHPS process and a review of the steps taken within that process, to include any follow up action. As part of this examination, it was

[1] TRU-292402 to TRU-292449

necessary to assess whether it was appropriate to initiate a formal process under MHPS at that time and to consider whether the process could or should have been utilised at an earlier stage or at all.

ii. The Inquiry was further asked to determine whether the application of the Framework was effective. This required an assessment of the aims of the Framework to understand why it was put in place and what factors may have impacted on its effectiveness. In considering the effectiveness of the Framework, it was also important for the Inquiry to bear in mind that additional concerns regarding Mr O'Brien's clinical practice emerged in 2020, less than two years after the investigation under MHPS concluded, which had not been identified during that investigation.

iii. Finally, the Inquiry was required to make recommendations to 'strengthen' the Framework if required. As set out below in paragraphs 321 to 335, we have been drawn to the conclusion that rather than seek to amend the existing Framework, there are good grounds for suggesting a new approach altogether.

Identification and knowledge of concerns prior to 2016

4. For many years before the Trust commenced a formal investigation in connection with Mr O'Brien's practice, some of his colleagues within the Trust's urology service, as well as those responsible for managing him, were aware of shortcomings in his professional performance. Whilst, over the years, a variety of informal steps were taken to address those shortcomings, the Trust did not seek to initiate any structured or formal investigation of Mr O'Brien's practice.

5. Term of Reference (a) requires the Inquiry:

"To review the Southern Health and Social Care Trust's (the Trust) handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice.

> The Inquiry shall determine whether there were any related concerns or circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and making complaints."

6. This section of the chapter examines the identification and knowledge of concerns in respect of Mr O'Brien's practice prior to the initiation of the formal investigation in 2016 in considering whether there were circumstances which should have prompted the Trust to instigate an earlier and more thorough investigation.

'The Hagan Concerns' (2000)

7. Between February and August 2000, Mr Chris Hagan, now Consultant Urologist and Medical Director of the Belfast Health and Social Care Trust (Belfast Trust), worked in the Urology Department in Craigavon Area Hospital (CAH) for six months as part of his training rotation. Mr Hagan told the Inquiry that, during this six-month period:

> "there were a number of situations that arose that caused me to feel concerned about some of the practices of Mr. O'Brien."[2]

8. We recognise that the concerns identified by Mr Hagan relate to events over 20 years ago and that recollection will, naturally, be hindered by both the passage of time and the unavailability of records. Some of the issues raised by Mr Hagan have been corroborated by other evidence, and his recollections have clearly left an impression on him. It is not our role to determine whether, in clinical terms, the concerns raised by Mr Hagan are entirely accurate or valid and, to be clear, we do not purport to reach any conclusions in that regard. However, the response to any concerns raised – whether or not those concerns are justified – is firmly a matter within the Inquiry's remit.

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2 WIT-98844, paragraph 28

9. Mr Hagan outlined that he had concerns about the following issues:

- Cystectomy and Orthotopic Neobladder Formation
- Long Transurethral Resection of the Prostate (TURP) procedure
- Ureteric Stone Treatment/Use of Electrohydraulic (EHL) Stone Fragmentation Device
- Paediatric Urology
- Radical Prostatectomy
- Priapism and Penile Disassembly
- Outpatient Practice.
- Administrative Delay

Cystectomy and Orthotopic Neobladder Formation

10. Mr Hagan recalled that, amongst a number of patients attending the ward for antibiotic therapy and IV fluids, was a female patient in her early twenties who had had a cystectomy (a major operation to remove the bladder) and neobladder (creation of a new bladder) to treat recurrent urinary tract infections (UTIs). Mr Hagan explained that the patient had "made a lasting impression" on him:

> "as she was really miserable, especially as she was continuing to have UTIs notwithstanding the major operation she had been put through."[3]

Mr Hagan explained that it is:

> "highly unusual to remove the bladder in young people unless there's some very unusual congenital abnormality. … I remember searching the literature … and couldn't find any series of patients who had had cystectomy, neobladder formation for a recurrent urinary tract infection."

[3] WIT-98846, paragraph II

It was Mr Hagan's recollection that, when he challenged Mr O'Brien as to why he had carried out:

> "such a radical and life changing operation on this young woman in the context of recurrent UTIs" [4]

Mr O'Brien remarked "that someone else had said that to him" and justified it by telling Mr Hagan that he had discussed the case with a Urologist in the United States of America who agreed it had been a reasonable course of action.[5]

11. Mr O'Brien could not recall the case in question.[6] Mr Hagan told the Inquiry that, looking back now with 17 years' experience as a consultant urologist, he "can see no justification for the operation."[7] Both Mr O'Brien and Mr Michael Young agreed that it would be very unusual, in the absence of other pathology, to perform such an operation for recurrent UTIs.[8] The Trust advised the Inquiry that they were unable to locate any documentation relating to a benign cystectomy being carried out on a young woman.

Long TURP procedure

12. Transurethral Resection of the Prostate (TURP) is a core urological procedure to treat an enlarged prostate and remove symptoms of bladder outlet obstruction. TURP is generally a safe procedure but, as with all medical procedures, carries some risks. One such risk is a rare, but life-threatening condition called TUR syndrome, which is caused by absorption of Glycine fluid. Amongst others, a key risk factor for TUR syndrome includes resection time greater than one hour.[9] Mr Hagan told the Inquiry that a core tenet of the training he had experienced in Glasgow, Belfast and Dublin was that:

4 TRA-07903, lines 17-27; WIT-98846, paragraph II
5 WIT-98846, paragraph II
6 WIT-107581, paragraph 53
7 WIT-98846
8 WIT-107581, paragraph 53; WIT-103606, paragraph 2.01
9 WIT-98847, paragraph III

"resection must stop no later than an hour, and ideally cease by around 50 minutes (to allow for another 10 minutes to control any bleeding)."[10]

13. During his time in CAH, Mr Hagan recalled witnessing Mr O'Brien carrying out a TURP procedure involving a resection time approaching two hours. He recalled:

"the anaesthetist and nursing staff expressing concerns to Mr. O'Brien about the length of operating time, but Mr. O'Brien continued."[11]

Mr Hagan told the Inquiry that he expressed his concerns that this placed the patient at unnecessary risk to Mr O'Brien and that Mr O'Brien's view, to his recollection, was that resection time was not the significant issue that Mr Hagan considered it to be. Mr Hagan believed he also spoke to Mr Young about the issue who, to his recollection, replied "that's just Aidan."[12] Understandably, given the passage of time, Mr Hagan sought to qualify this recollection:

"I cannot say for certain that the remark from Mr. Young that I recall was definitely in connection with this issue, but it is definitely a phrase that Mr. Young used to me when I raised an issue about Mr. O'Brien during my time in CAH."[13]

14. Mr Young did not recall a precise conversation with Mr Hagan about this case.[14] With regard to the use of the phrase 'that's just Aidan', Mr Young admitted it was a phrase he, as well as others, "would have used in general terms" but maintained it would not have been a phrase he would have used when responding to someone commenting on a TURP of that duration.[15] However, Mr Young conceded he was "generally aware that Mr O'Brien had on occasions taken more than 1 hour for a TURP" but described this as "theatre tea room

10 WIT-98847, paragraph III
11 WIT-98847, paragraph III
12 WIT-98847, paragraph III
13 WIT-98847 to WIT-98848, paragraph III
14 WIT-103608, paragraph 3.3
15 WIT-103608, paragraph 3.4

chat".[16] The Inquiry has seen the results of an audit conducted in May 2014 in respect of glycine irrigating fluids and sodium levels during TURP/TURBT surgery.[17] The audit found that the average length of TURP procedures was 39 minutes, with a range from 13 to 90 minutes.[18] 9% of TURP procedures were found to take longer than 60 minutes.[19]

15. Mr O'Brien could not recall any TURP procedure coming close to two hours and told the Inquiry that, amongst all of the estimated 3000 TURPs performed during his career, he has experienced only three or four potentially symptomatic cases of TUR syndrome, and none with any severe symptoms.[20]

16. Historically there were no regular audits of the length of TURP or TUR syndrome and so the use or audit as an improvement tool was not evident in this area of practice. The audit in May 2014 appears to have been a one off.

Ureteric stone treatment/use of electrohydraulic stone fragmentation device

17. Mr Hagan described two distinct, but related, concerns in respect of Mr O'Brien's treatment of ureteric stones. The first concerned Mr O'Brien's approach to the management of ureteric stones, which Mr Hagan described as being "very different" to the conservative approach he had experienced when working in Glasgow and Belfast.[21] Mr Hagan explained that Mr O'Brien's preference was to intervene surgically "at a very early stage" and described his experience of challenging Mr O'Brien at the time:

> "I challenged him in relation to this approach, as I felt that suitable stones should be allowed to pass naturally. This is because intervention carries risks, … Mr. O'Brien however referred to his training in Tallaght Hospital in Dublin, and that this was how he managed stones. Generally, I found Mr. O'Brien to

16 WIT-103609, paragraph 3.6
17 AOB-82839 to AOB-82868
18 AOB-82847
19 AOB-82848
20 WIT-107582, paragraphs 56 and 57
21 WIT-98848, paragraph IV

be dismissive of me when I raised concerns. He was clear that it was an appropriate course of treatment."[22]

18. In Mr Young's early days as a consultant, he found Mr O'Brien's approach was different in that he did not use a safety guidewire, nor X-ray screening for ureteroscopy. Apart from this, Mr Young did not find Mr O'Brien's approach to be very different in terms of the timing of the intervention.[23]

19. The second issue Mr Hagan described related to the energy source used by Mr O'Brien in the destruction of stones. It was Mr Hagan's evidence that Mr O'Brien preferred an EHL energy source, which was "powerful and unpredictable" and carried a high risk of ureteric perforation when used in the ureter.[24] Mr Hagan explained that he argued in favour of using a Swiss lithoclast but described Mr O'Brien as having dismissed his concerns.[25] Mr Hagan told the Inquiry of a case in which, under Mr O'Brien's direction and supervision, he used an EHL probe to fragment a ureteric stone and caused a very large perforation in the upper third of the patient's ureter, which necessitated open surgical repair. Mr Hagan described being "distressed by this complication" but told the Inquiry that, with hindsight, it is clear to him that the direction he received from the supervising consultant to use EHL was not appropriate in the situation and that this was an entirely avoidable complication.[26]

20. Mr O'Brien told the Inquiry that he had no recollection of discussing the need for a more conservative approach with Mr Hagan; that he had no training in Tallaght; and that he only intervened surgically when clinically indicated and in accordance with well-established criteria.[27] Mr O'Brien highlighted that the notes for the operation do not record his presence, nor that he supervised the procedure, only

22 WIT-98848, paragraph IV
23 WIT-103610, paragraph 4.5 and 4.6
24 WIT-98848, paragraph IV
25 WIT-98848, paragraph IV
26 WIT-98849, paragraph IV
27 WIT-107584 to WIT-107585, paragraph 63

that Mr Hagan had informed Mr O'Brien.[28] Further, the Trust has confirmed that alternative energy sources were not available within the Trust at that time.[29]

Paediatric urology

21. Mr Hagan described Mr O'Brien having acquired a set of paediatric cystoscopes (a medical instrument used during cystoscopy, a procedure to examine the bladder and urethra). Mr Hagan explained that he thought this was:

> "very unusual as there are very few indications for cystoscopy in a child, and usually it will be in children with congenital conditions or vesico-ureteric reflux (both of which would be managed in tertiary specialist centres)" [30]

but he was clear that he did not witness Mr O'Brien performing a cystoscopy on a child.

22. Mr Hagan further described an occasion on which he and Mr O'Brien disagreed over the management of a child with nocturnal enuresis. He told the Inquiry:

> "Mr. O'Brien was of the view that the child required invasive tests such as urodynamics (which requires a general anaesthetic and catheters). In my view at the time this was over-investigating and unnecessary, as the course of treatment would be expected to be the same in any event. I cannot say whether Mr. O'Brien did in fact carry out the invasive tests, I just remember disagreeing with him when he thought this should be the course undertaken."[31]

23. Mr O'Brien had no recollection of the case described by Mr Hagan but explained that the paediatric cystoscopes were rarely used and were only used in relation

28 TRU-320247 to TRU-320248; WIT-107586, paragraph 64
29 TRU-320243
30 WIT-98849, paragraph V
31 WIT-98850, paragraph V

to older children, where they offered diagnostic value when examining the lower urinary tract.[32]

Radical prostatectomy

24. Mr Hagan considered that Mr O'Brien's patient selection for radical prostatectomy "differed to what was generally accepted by UK urologists at that time," although he recognised that there would have been some support beyond the UK for the approach Mr O'Brien advocated.[33] Mr Hagan explained that Mr O'Brien would have offered radical prostatectomy to men with very high Prostate Specific Antigens (PSAs) and would commence them on hormone treatment prior to surgery to reduce their PSA score; Mr Hagan's concern was that this approach provided no ultimate benefit in these cases and risked earlier hormone resistance in these patients. It was Mr Hagan's recollection that Mr O'Brien disagreed and would have "openly" disagreed with others in the region on the issue of the treatment of prostate cancer.[34]

25. Mr O'Brien told the Inquiry that staging (determining how large a cancer is and how far it has spread) performed by MRI scanning was undertaken prior to any patients being prescribed neo-adjuvant androgen deprivation therapy (ADT) and explained that the latter:

> "was not initiated in order to reduce serum PSA levels but instead to prevent disease progression while awaiting surgery."[35]

Priapism and penile disassembly

26. Mr Hagan recalled the case of a patient who had been admitted with a long-standing priapism (an enduring erection of the penis):

32 WIT-107586 to WIT-107587, paragraphs 65-67
33 WIT-98850, paragraph VI
34 WIT-98850, paragraph VI
35 WIT-107587, paragraphs 68-70

> "Andrologists (physicians who specialise in treating men's reproductive-related issues) in Great Britain were recommending early referral to London for insertion of artificial penile prosthesis for management of this rare condition. However, in the case I remember, Mr. O'Brien took the patient to theatre and performed what I can only describe as a penile disassembly … I just remember being present in the theatre at some point and wondering what Mr. O'Brien was trying to achieve. … I remember leaving the theatre as I did not want to watch what was happening. I never found a description of the procedure in any text."[36]

Neither Mr O'Brien, nor Mr Young, recalled this case.[37] The Trust could find no evidence in its records of such a case.

Outpatient practice

27. During his rotation, Mr Hagan assisted with Mr O'Brien's clinics, which he described as being "busy with large numbers of patients."[38] Mr Hagan recalled encountering review patients who were on repeat follow up appointments, for which he could discern no clear rationale.[39] He explained that he would, therefore, try to discharge as many patients as possible to improve clinic efficiency. He provided the following example:

> "I recall one specific patient who I discharged from clinic in Banbridge for this reason, but who was then back at the clinic the following month. His symptoms had not deteriorated or changed and I asked him how he had been re-appointed. The patient told me that he had phoned Mr. O'Brien's wife (who I believe assisted Mr. O'Brien with his private patients) who arranged (presumably with the clinic's appointment secretary) for him to be re-instated

36 WIT-98851, paragraph VII
37 WIT-107588, paragraph 72; WIT-103611
38 WIT-98851, paragraph VIII
39 WIT-98851, paragraph VIII

on the clinic. … As I reflect on this now for the purposes of this statement, I realise that was an unusual practice that was occurring."[40]

28. Mr O'Brien had no recollection of this patient or this event. He told the Inquiry that, while patients (both private and health service) would have contacted his home and may have spoken to his wife, she would simply have taken a message. He insisted that his wife:

> "never arranged any review or any other service of any kind for any patient who contacted me by calling my home".[41]

Mr O'Brien speculated that the patient may have been dissatisfied with some aspect of his review by Mr Hagan and that a further review was requested.[42]

Administrative delay

29. Reflecting, with the benefit of hindsight and his own professional experience, Mr Hagan characterised Mr O'Brien's administrative processes as "appearing disorganised and chaotic."[43] He recalled that Mr O'Brien's office was always full of patient charts awaiting dictation, that these took "a considerable time" to process, and that Mr O'Brien's secretary would have complained about this.[44] With hindsight, Mr Hagan attributed this to what he described as Mr O'Brien's "tendency to over investigate patients" and to write "extremely long letters, which often seemed to struggle to get to the point."[45] Mr Hagan reflected:

> "It is of course easy to criticise the practice of others, but it is obviously important, when writing letters to GPs, that they are timely, and that the diagnosis and management plan is succinct and clear."[46]

40 WIT-98851 to WIT-98852, paragraph VIII
41 WIT-107589, paragraph 74
42 WIT-107589, paragraph 75
43 WIT-98852, paragraph IX
44 WIT-98852, paragraph IX
45 WIT-98852, paragraph IX
46 WIT-98852, paragraph IX

30. Mr O'Brien rejected Mr Hagan's assertions that his administrative processes appeared disorganised and that he over-investigated patients. With regard to the length of his letters, Mr O'Brien explained:

> "I do not believe that it [sic] struggled to get to the point, as I believe the point was to provide the GP with a record of the patient's management, and to have such a record for future reference by others. It may be that it did contribute to administrative delays, but I considered it better to have a properly informative record than to have one that was timely but not adequately informative."[47]

31. As set out above, Mr Hagan recalled challenging Mr O'Brien directly in relation to some of his concerns and, on other occasions, having spoken to Mr Young, who was the other consultant at the time. Both Mr O'Brien and Mr Young reported having limited or no recollections of these cases and of Mr Hagan having raised concerns.

32. Mr Hagan readily acknowledged that he did not keep a formal record of his concerns as it would not have occurred to him to do so at the time. However, he explained

> "I did raise issues that concerned me with Mr. O'Brien himself, and also with Mr. Young about Mr. O'Brien, during my 6 months rotation. In 2000 that would have seemed like a brave or courageous step from a higher surgical trainee. I am sure I probably saw it that way at the time. Whereas, with all the more recent and ongoing changes in medical culture (transparency, openness and the many mechanisms for raising concerns) and the development of clinical governance … it hardly seems sufficient by today's standards when the opportunity for trainees to raise concerns are much more organised and available, and their use encouraged. Trainees are now heard and listened to in a way they would not have been in 2000."[48]

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47 WIT-107590, paragraph 78
48 WIT-98844 to WIT-98845, paragraph 28

This was also recognised by Mr Young, who agreed that, as a Registrar:

> "sometimes it is hard to raise things and it takes a bit of courage to actually challenge something".[49]

33. The Inquiry recognises that the voice of the trainee has gained prominence in recent years as, with the growth of multi-disciplinary practice has the voice of others on the team. This is important progress in patient safety terms and should be encouraged and fostered.

34. On careful consideration of the evidence, we consider it likely that Mr Hagan *did* raise some concerns with Mr Young and Mr O'Brien at the time, as he has described. Raising a concern about a consultant colleague, particularly as a trainee, was – and remains – a courageous thing to do. Mr Hagan is to be commended for doing so in the circumstances at the time.

35. The Inquiry recognises that Mr Hagan's recall may be imperfect in terms of detail and has undoubtedly been affected by the passage of time. His recollection is demonstrably incorrect in some cases. Moreover, the significance of him raising any concerns may not have been obvious to either Mr Young or Mr O'Brien at the time. We are of the view that whatever he did say was not given much credence and that the extant clinical governance systems did not assist. More is said about this in the Governance chapter.

36. Whether or not Mr Hagan raised the specific issue of Mr O'Brien performing lengthy TURP procedures, it is clear that Mr Young nevertheless had knowledge of this issue.[50] Despite that knowledge, and his own recognition that it was:

> "a wee bit of an alarm bell to say here is somebody that keeps on operating beyond the hour."

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49 TRA-09685, lines 16-18
50 TRA-09689, line 18 to TRA-09690 line 13

Mr Young, who was then the Clinical Lead (CL), did not raise the issue with Mr O'Brien.[51] Nor has the Inquiry seen any evidence to suggest that he raised it with anyone else. When asked about this by Counsel to the Inquiry, Mr Young offered the following:

> "Again, it comes back to how long is a piece of string? An operation starts and finishes. You know, you have to get all the joined up writing in the middle of that. I'm not entirely sure my responsibility of what you're saying here. I mean, this is a team approach. There's the recovery staff, there's the admissions to intensive care, there's the anaesthetic service. It is all very live and observing. Are cases like this brought to the Patient Safety Meeting, you know, if there was a complication as such. So I understand what you're saying. There could be a conversation held: Yes, Mr. O'Brien, why are you being observed to be operating for more than an hour? An answer could be: I was completing the operation, you know, and I haven't had any problems."[52]

37. We are not persuaded by Mr Young's explanation of his failure to speak to Mr O'Brien about this issue. His assumption that there may have been a valid explanation does not excuse his failure to ask the question. As CL, at the very least, Mr Young should have spoken to Mr O'Brien to ascertain why some of these procedures were taking so long. Without doing so, and without regular metrics in place to identify poor practice, he could not be assured that there were not issues of serious concern with how Mr O'Brien was carrying out, or managing, these procedures. The Inquiry notes that no comparative data on operation times, or complication rates, or return to theatre rates, was in place for TURP procedures at the Trust, and we saw no evidence that Mr O'Brien was any different from his colleagues in terms of operation times or complication rates.

38. It is of note that the role of CL was not clearly described, and Mr Young appears not to have understood what was required in terms of clinical governance and

51 TRA-09693, lines 16-18; TRA-09690, line 27
52 TRA-09693, line 23 to TRA-09694, line 8

patient safety. This was accentuated by a lack of sufficiently clear and effective medical management and leadership overseeing urology services. The clinical team was committed to providing a good service and discussing such matters that were felt to be important such as complications from surgery or difficult cases but there was a lack of a developed system for identifying poor practice. More is said about this in the Governance chapter.

IV antibiotics (2000)

39. During his rotation in 2000, Mr Hagan described having witnessed a group of patients who were regularly admitted to the ward by Mr O'Brien for antibiotics and IV fluids.[53] He recalled the ward nurses referring to this treatment as "*Mr. O'Brien's regime*".[54] Mr Hagan explained that the reason for the approach was unclear to him and that he was unaware of the evidence base for the treatment. He considered that patients who fell into this category could have been managed as outpatients as they could eat and drink and told the Inquiry that he did not encounter this approach in any other urological unit he worked in either before or since.[55] Mr Young told the Inquiry that, in 2000, he would not have followed this approach to treating patients and agreed with Mr Hagan "that it was maybe not standard practice".[56] Mr O'Brien readily accepted that, at that time, he was aware that this approach was somewhat novel and not practised elsewhere.[57] He estimated that he may have commenced this therapy in the late 1990s.[58] Mr Young said he would have challenged Mr O'Brien about this on the ward round, however, it appears that this issue was not escalated as a concern at that time.[59]

40. It was not until March 2009, when correspondence was received from an MLA regarding two patients requesting self-care in the community, that this practice

53 WIT-98845, paragraph 31.l
54 WIT-98845, paragraph 31.l
55 WIT-98845 to WIT-98846, paragraph 31.l
56 TRA-09697, lines 5-8
57 TRA-12398, lines 25-29
58 TRA-12399, lines 14-19
59 TRA-09697, line 29; TRA-09698, line 3

was subjected to scrutiny. The letter explained that the patients were required to attend hospital every six to eight weeks, for a period of five days, to receive treatment.[60] Around this time Ms Joy Youart (then Director of Acute Services) carried out an audit of bed usage and identified a cohort of 34 patients who were being re-admitted to CAH for intravenous fluids and antibiotic therapy.[61] Unclear as to what the indications for the treatment were, she escalated the issue to Dr Patrick Loughran, then Medical Director of the Trust.[62] Dr Loughran told the Inquiry that he contacted Mr Mark Fordham (a senior Urologist in Liverpool) and Dr Jean O'Driscoll (a senior Microbiologist) by telephone about the issue, both of whom "advised that there was no scientific basis for the treatment."[63]

41. Separate to this, at some time between January 2008 and December 2010, Dr Tracey Boyce, (Director of Pharmacy and Medicines Management), recalled an experienced clinical pharmacist having approached her with a clinical concern regarding Mr O'Brien's practice of admitting patients for five or more days to receive an infusion of Gentamicin (an antibiotic).[64] Dr Boyce explained that the concern was that the dose being prescribed was subtherapeutic and that: "The patients all appeared to be clinically well."[65] She summarised the significance of the issue in the following terms:

> "Patients were being exposed to the side effects of medicine unnecessarily, being cannulated for no reason and being put at risk of acquiring an infection whilst in hospital. Further, by giving low doses of the antibiotic, there was a risk that antimicrobial resistance could develop which would render that antibiotic ineffective if they actually needed it in the future. In addition to this, the Trust was under huge pressure for beds at the time and these patients were taking up a valuable resources [sic] unnecessarily."[66]

60 PHA-00437
61 PHA-00438
62 WIT-15423, paragraph 28
63 WIT-15424, paragraph 28; PHA-00440; TRU-250967 to TRU-250968
64 WIT-87656, paragraph 27.6; WIT-87655, paragraph 27.2
65 WIT-87655 to WIT-87656, paragraph 27.4
66 WIT-87656, paragraph 27.5

Whilst Dr Boyce could not confidently place this interaction in time, she confirmed that she also escalated the issue to Dr Loughran.[67]

42. Mr O'Brien explained his rationale for the approach:

> "We wondered whether we could prevent these patients becoming repeatedly so acutely unwell, requiring acute re-admission, by having them electively readmitted prior to acute readmission. By analysing the periods of time that had elapsed between acute readmissions, we were able to determine a planned date for elective re-admission for intravenous hydration and antibiotic therapy. Prior to doing so, we had already found that pre-emptive oral antibiotic therapy in the community had been ineffective and had only delayed their acute re-admission. So, we electively re-admitted patients, usually 2 weeks prior to their otherwise, anticipated acute re-admission. We also hoped that by doing so, we would be able to lengthen the periods of time between elective re-admissions, while hopefully preventing acute re-admission."[68]

43. The Inquiry discusses this issue as one of the clinical aspects that it looked at in the Clinical Aspects chapter. We are firmly of the view that this practice ought only to have been attempted as part of a controlled trial amenable to audit and challenge.

44. Mr O'Brien's references to 'we' are inclusive of Mr Young, who was also – by this time – admitting patients for intravenous antibiotics, albeit he distinguished his approach from Mr O'Brien's, claiming that he adopted this approach for patients who had an infection, and for whom treatment with oral antibiotics did not appear to be working, whereas Mr O'Brien's patients "were more often admitted electively without a proven infection."[69] Mr O'Brien made the point that Mr Young's admissions were, nevertheless, elective admissions and, therefore, any distinction is minimal.[70]

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67 WIT-87656, paragraph 27.6
68 WIT-82548 to WIT-82549, paragraph 420
69 TRA-09699 to TRA-09701
70 TRA-12403, lines 3-28

45. There is clearly a difference in admitting patients with no proven infection versus those with proven infection and while the Inquiry has no reason to doubt Mr Young, we consider that he too ought to have sought microbiology advice regarding these patients, we have seen no evidence that he did so any more than Mr O'Brien.

46. In April 2009, a meeting took place between Dr Loughran, Dr Charles McAllister (Consultant Anaesthetist and Intensivist), Dr Nizam Damani (Consultant Microbiologist) and Mr O'Brien, at which compliance with the Trust Antibiotic Guidance was discussed. The notes of the meeting record Mr O'Brien as having said that:

> "his personal experience would support the antibiotic use as he currently followed and he was not persuaded to adopt the Trust advice."[71]

In response to this, it was agreed that Dr Damani and the urology team would meet to agree the guidelines as applied to urology. Dr Loughran is recorded as having asked for the final agreement to be evidence-based. With regard to the cohort of patients identified by Ms Youart, Mr O'Brien described the evidence base and a study of the outcome which was being prepared for publication. Dr Loughran agreed to contact Dr Diane Corrigan (the Public Health Agency (PHA) adviser to the Southern Health and Social Care Board (HSCB) office) regarding the two patients seeking self-care in the community.

47. Dr Loughran sought Mr Young's views, as Lead Clinician. His notes of the discussion suggest that Mr Young:

> "Expects the evidence base is not there to support the therapy but clinical experience supports use.

[71] PHA-00439

He expects an independ [sic] inspection will not support the therapy but then patients will be unhappy."[72]

When Dr Loughran spoke to Mr O'Brien, Mr O'Brien continued to defend his approach and requested: "an in depth look at the cohort.. not just telephone contact with specialists".[73]

48. In follow-up correspondence to Mr O'Brien in May 2009, Dr Loughran explained that his discussions with independent experts had not identified any evidence to support the treatment. He further advised Mr O'Brien that the Commissioner (Dr Diane Corrigan) had expressed concern and asked him to seek independent advice so that an evidence-based discussion could take place around the continuation or discontinuation of such therapies.[74] The correspondence did not instruct Mr O'Brien to cease prescribing this therapy, but rather asked him to:

"reflect on the possibility of changing these patients to oral therapy with an MSSU taken at the hospital at a regular interval."[75]

49. At the beginning of June 2009, Mr O'Brien agreed to provide Dr Loughran with a list of the patients on the IV programme and to accept an independent assessment of his IV therapy.[76] Mr O'Brien failed to furnish the list, as agreed, and Dr Loughran ultimately obtained the list from Ms Youart.[77] In July 2009, Dr O'Driscoll and Mr Fordham were invited to provide a formal assessment.[78] In the letters of instruction to the independent experts, Dr Loughran stated:

"I have continued to negotiate with the consultants involved to see if they would discontinue this practice without any success. Unfortunately they

72 PHA-00440
73 PHA-00440
74 TRU-250965 to TRU-250968
75 TRU-250968
76 TRU-250969
77 WIT-15358 to WIT-15359
78 TRU-250981 to TRU-250984

remain unconvinced that their practice is an unconventional method of treatment and of limited or no benefit to the patients."[79]

50. Subsequently, in August 2009, Mr Young and Mr O'Brien met with Dr Loughran.[80] It was agreed that a multidisciplinary group, comprising microbiology and urology consultants, would be convened to review the reduced list of patients and agree a treatment plan for each patient. The core of this treatment plan was to convert the patient from IV to oral therapy or another non-intravenous treatment.[81] Dr Damani agreed to provide microbiology support.[82]

51. On 01 December 2009, the issue was discussed at a urology service meeting at which the Acting Chief Executive (Ms Mairead McAlinden), the Medical Director (Dr Loughran), the AMD (Mr Eamon Mackle) and the Interim Director of Acute Services (Dr Gillian Rankin) were present.[83] It was reported that a cohort of 38 patients were receiving the treatment at that time:

"even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009."[84]

It was agreed that a professional opinion would be sought from Mr Fordham and that, depending on the outcome of the assessment, management may need to take action to inform the Commissioner if practice was not safe; issue a letter to Mr O'Brien and Mr Young requiring them to change clinical practice, with a clear indication of sanctions if this did not happen; and to obtain professional assessment of the full cohort of 38 patients.[85] Ultimately, it was Mr Fordham's opinion that the regime did not have a scientific evidence base; that there was no need to treat patients who are able to drink normally with IV fluids; and that there were other, more appropriate, antibiotic regimes available.[86]

79 TRU-250981
80 TRU-250996
81 See memo at TRU-281845 to TRU-281846
82 TRU-250996
83 WIT-11850 to WIT-11851
84 WIT-11850, paragraph 2.1
85 WIT-11851
86 PHA-00451

52. On 19 July 2010 Mr Mackle wrote to Ms Anne Brennan raising concerns that there were still 13 to 14 patients receiving IV treatment and requesting a copy of Mr Fordham's report and minutes of his meeting, as he was planning to meet with Mr Young and Mr O'Brien.[87] In September 2010, Dr Diane Corrigan wrote to Dr Loughran expressing her concern that the practice of treating patients with IV fluids and antibiotics was continuing and that some patients were now receiving the treatment through central lines. Dr Diane Corrigan sought a report from the Trust detailing what steps were being taken:

> "to manage the ongoing risks associated with delivering IV therapies to the original cohort of patients"[88]

and sought a position statement detailing how many patients were still receiving this form of treatment and the expected timeframe for it to cease.

53. A memo from Dr Loughran to Dr Rankin (Interim Director of Acute Services) the following day advised that the agreement reached in August 2009 had not been followed by Mr O'Brien and Mr Young. At that time, at least seven patients remained on the IV treatment and two (possibly three) had permanent intravenous access. Dr Loughran expressed his continued concern that any patient was receiving this "unusual" intravenous treatment.[89] At Dr Loughran's request, Dr Rankin and Mr Mackle subsequently met with Mr O'Brien and Mr Young. A case review process chaired by the Clinical Director (CD) of Surgery and Elective Care (Ms Samantha Sloan), involving Dr Damani, was set out.[90] Mr Young agreed to be involved in the process of clinical review of each of his patients who were receiving IV fluids and antibiotics.[91] Mr O'Brien stated that patients may become less well as a result of withdrawal of IV antibiotics but agreed to remove the PICC line (Peripherally Inserted Central Catheter) in a

87 TRU-251107
88 TRU-251161 contained within letter at TRU-251158 to TRU-251161
89 TRU-281845 to TRU-281846
90 TRU-251141 to TRU-251144
91 TRU-281854 to TRU-281855

patient who was due to have surgery in the next two weeks.[92] The following week, Dr Loughran responded to Dr Diane Corrigan's letter, assuring her that the therapy was to cease and that:

> "No further patients can be commenced on this treatment and under no circumstances can central venous access be used for treatment of recurrent urinary tract infections."[93]

The Trust Board was briefed on the issue, and the steps taken in response, at a confidential meeting on 30 September 2010.[94] Mr O'Brien's 2010 appraisal record noted that the issue had been "satisfactorily concluded."[95]

54. Dr Rankin told the Inquiry, "there definitely was resistance" to the Trust's attempts to resolve this issue.[96] Indeed, in his evidence to the Inquiry, Mr O'Brien remained critical of the Trust's approach:

> "It is my view that, that [sic] an independent review process would have been considerably more robust had the Trust provided the independent reviewers with an opportunity to consult with the clinicians who managed these patients who would have accurately informed the experts of the reason and purpose of their management. It remains incomprehensible to me how any responsible clinicians could deny to patients an effective form of treatment to prevent their worsening conditions requiring their acute admissions for the same treatment for longer periods of time, all other usual preventative treatments having been found to be ineffective."[97]

92 TRU-281856 to TRU-281857
93 TRU-251192 to TRU-251193
94 WIT-17008 to WIT-17012
95 TRU-251244; TRU-251248
96 TRA-06415, line 6
97 WIT-107570, paragraph 21

However, he ultimately accepted that he ought to have sought permission before commencing therapy which had not been commissioned and did not fit within a recognised patient care pathway at the time.[98]

55. In August 2011, Mr Vincent Koo wrote a letter regarding the use of short-term intravenous fluids and antibiotic therapy in recurrent UTIs to the editor of the Journal of Infection.[99] This letter was co-signed by Mr O'Brien and Mr Young. The letter concluded:

> "IVT is beneficial for a carefully selected patient with rUTI and their treatment should be individually tailored. We do not claim to know the optimal duration of treatment and regularity of IVT regime, but suggest that it should be adapted to patient's condition. It is hoped that this report will serve as a pilot assessment of its efficacy and proof of concept to allow for future randomised trials."[100]

Mr O'Brien denied that the publication of this letter was in any way a demonstration of defiance towards the Trust, explaining that the authors "simply reported our experience."[101]

56. The account of this issue has been set out in detail as it illustrates reasonably good handling of a concern by the Trust's leadership once the issue was escalated. However, it was not escalated through internal clinical governance processes.

57. Normally when guidelines are introduced there is consultation with clinical staff and modifications can be agreed if signed off by the senior responsible clinician. Clinicians are required to accept Trust guidelines and to only deviate by exception, with good reason and based on evidence. They cannot wait to be

98 TRA-12412, line 27 to TRA-12413, line 28
99 WIT-82743 to WIT-82745
100 WIT-82744 to WIT-82745
101 TRA-12425, line 11 TRA-12426, line 13

'persuaded' to do so.[102] This issue is an example of an attitude often displayed by Mr O'Brien, that he knows best. More is said about this in the Clinical Aspects chapter.

58. Clinical guideline adherence should be audited from time to time. Had this been done within the Trust, the IV antibiotic issue could have been identified internally and addressed. Board members and senior staff referred the Inquiry to better systems for disseminating guidelines. This is a good first step but unless clinical staff know they must work to those guidelines or evidence the need for exception then dissemination is meaningless.

59. Moreover, while a clinician can feel so strongly that they ask for further advice to corroborate their view, they should not feel it acceptable to just do their own thing without properly informing senior medical professionals. This is contrary to Good Medical Practice (GMP).[103]

60. The question of whether this treatment was effective or not is not one which the Inquiry needs to determine. Mr O'Brien and Mr Young engaged in the practice outwith Trust guidelines. It had not been commissioned and it drained Trust resources. The Trust as employer was entitled to demand it be stopped.

The 2009 meeting

61. Dr Rankin was a General Practitioner (GP) with managerial experience in Public Health. She was appointed as the Interim Director of Acute Services in 2009. She took on the substantive post in 2011 and retired in 2013.

62. The Inquiry found her to be an energetic, clear thinking and hard-working manager who had a good handle on all aspects of her directorate and made considerable efforts to improve governance. We formed the impression that her

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102 See paragraph 49 above
103 INQ-30854, paragraphs 22-27; INQ-30862, paragraph 85, GMC Good Medical Practice, Domain 1

personal energy and attention to detail helped to provide impetus for coordinated efforts in what was clearly a very busy directorate. The directorate was under extreme pressure, waiting list targets were slipping and there were shortages of medical staff. She had a great deal of contact with urology as she was instrumental in leading a significant piece of work to modernise and improve the way urology services were to be delivered. This plan known as Team South Urology was to lead to an expansion in consultant numbers and was supported by commissioners.

63. Dr Rankin described a critical meeting on her first day as an interim director:

> "Issues in relation to the urology service were raised with me on my first day in post i.e., 1st December 2009. This was through a meeting chaired by the Chief Executive, which alerted me to the current and ongoing issues. The regional Review of Urology had reported but was not yet signed off by the Minister. The development of the Implementation Plan for Team South Urology had commenced and I subsequently chaired a weekly /fortnightly meeting with the consultants involved to get agreement on the implementation plan and its implementation."[104]

She went on to describe the range of issues discussed at that meeting and the action agreed:

> "i Demand and capacity and the need to optimise the use of clinical sessions;
> ii Quality and safety - Medical Director to discuss with Mr Fordham seeking an urgent professional opinion on:
> A The appropriateness and safety of the current practice of IV antibiotics;
> B Triage of referrals and 1 consultant refusing to meet the current standard of triaging within 72 hours;

[104] WIT-15780, paragraph 1.2

C Red flag requirements and 1 consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately;

D Chronological management of theatre lists for theatre with 1 consultant keeping patients' details locked in the desk.

iii Action agreed that if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken."[105]

64. In her evidence to the Inquiry Dr Rankin was unable to recall the specifics of that meeting on her first day which she described as a "baptism of fire".[106] She recalls that there were both general and specific issues in urology and that she was aware that there were specific issues relating to Mr O'Brien. The meeting took place in the presence of both the Medical Director and the Chief Executive and was not part of a regular series of meetings.

65. Following this meeting Dr Rankin proceeded to deal with the various issues listed making significant progress on many of them as described in her witness statement. She described all the issues specific to Mr O'Brien that she encountered during her tenure:

"The specific issues in relation to Mr O'Brien related to the need to change behaviour in relation to some clinical practices and some administrative practices. The range of issues included;

a. Triage of red flag referrals i.e., referrals of people with potential cancer and non-urgent referrals.
b. The scheduling of patients for surgery without due regard to urgency and chronological order.
c. The surgical operation of cystectomy.
d. The use of IV antibiotics for inpatients.

105 WIT-15820, paragraph 28.3
106 TRA-06365, line 14

e. Referral of patients requiring prostatectomy or cystectomy to the Belfast Trust and the implementation of the regional MDM (multidisciplinary Meeting) to discuss each patient with cancer and agree their treatment.
f. Service capacity gap which impacted on the waiting time for patients for outpatients clinics, day case surgery, inpatient surgery and review outpatient appointments; and breaches of the 31 day and 62 day standards for patients with diagnosed cancer.
g. Failure to read test results when received and before filing the patient notes, irrespective of whether the patient has an outpatient appointment booked.
h. Disposal of some patient notes and information in the bin of a consultant's office."[107]

66. Some of the issues were robustly dealt with and followed to a conclusion such as the IV antibiotics issue outlined above, others less so. For example, in her witness statement Dr Rankin describes many meetings and firm attempts to influence Mr O'Brien's approach to triage including on one occasion preventing him from attending a BAUS conference in Barcelona until the triage was completed.[108]

67. She also described Mr O'Brien's reluctance to change his outpatient templates and new to review ratios. The issue of scheduling patients for surgery was only partially addressed.

68. In any case, despite failure to progress all issues to ultimate resolution, the original action from the 2009 meeting suggesting a referral to NCAS never occurred. This was almost certainly related to the large number of other issues and the pressures on the directorate.

69. When questioned in oral evidence Dr Rankin acknowledged that, with the benefit of hindsight a more robust approach to the continued issues related to the

107 WIT-15781, paragraph 1.7
108 WIT-15827, paragraph 30.2.a

practice of Mr O'Brien would have been appropriate and that the involvement of the Medical Director would have assisted this:

> A. "I can't really say why that didn't happen. I think it should have happened when I look back now and I see the range of issues, and perhaps that should have happened. I mean, we would have had many informal conversations about the Urology Service, and the consultant in particular. It's not that it wasn't known and wasn't in discussion. ... But nobody said right, let's put this all down on the table, let's look at this in the round and see what we need to do.
> Q. Who should have? Whose job was that, do you think?
> A. It would have been a combination of the Medical Director and myself. Either one of us could have said 'time to do this'. … And neither of us did."[109]

70. This was a missed opportunity to refer to NCAS in the context of a supported improvement plan and a missed opportunity to fully explore Mr O'Brien's difficulties in appraisal discussions where a deficit in audit was never corrected or really commented on except in a cursory way. Instead, the problems with triage and other issues were essentially regarded as administrative issues encountered in an overloaded department and the idiosyncratic approach taken by Mr O'Brien was in effect tolerated. It is likely that the turnover of Chief Executives and Medical Directors was a contributory factor in terms of organisational memory and the Chair of the Trust was conflicted. More is said about this in the Medical Management and Leadership chapter.

Inappropriate disposal of notes (2011)

71. In June 2011, an incident was reported which related to Mr O'Brien's inappropriate disposal of confidential patient information normally filed in the patient chart. A nursing assistant reported having found the material in a confidential waste bin and returned it to the ward clerk for filing in the patient's

[109] TRA-06480, lines 4-21

chart. The materials included, amongst other things, fluid balance charts, Gentamicin charts and prescription kardexes.[110] Due to the seriousness of the allegation, Mr Robin Brown (CD for Surgery and Elective Care) and Ms Zoë Parks (Medical Staffing Manager) were appointed to undertake a disciplinary investigation.

72. Mr O'Brien was interviewed as part of the investigation and accepted that he had acted inappropriately. He agreed that the material which had been removed from the chart was of value, should a case arise and require subsequent investigation and offered his assurances that it would not happen again.[111] In an email chain with Ms Martina Corrigan (Head of Service (HOS) for ENT and Urology) and Ms Heather Trouton (Assistant Director of Surgery and Elective Care), the Nurse Manager who had escalated the issue stated:

> "I hope the fact that this has been highlighted to him will deter any future issues of this kind but it could potentially happen again, as Sharon has pointed out this is not the first time this has happened."[112]

The Inquiry is concerned by this reference but has not seen any evidence to verify the suggestion that this occurred on more than one occasion.

73. The investigation report recorded the following conclusion:

> "I think that it is also important to note that Mr O'Brien says that he spends more time writing in and filing in charts than probably any other Consultant and from my own personal experience I can confirm that that is the case. Mr O'Brien has the utmost respect for patients, for their information and for the storage of records. This was an unusual behaviour which was the result of frustration from dealing with a large unwieldy chart, difficulties retrieving

110 TRU-278629
111 TRU-278631, paragraph 4.1
112 TRU-278636

important information from the chart, and from the difficulty finding anywhere suitable to make good quality records.

The motivation for the incident was honourable in that Mr O'Brien was trying to make an entry in the chart, though the solution to the problem was clearly wrong. I am satisfied that Mr O'Brien has accepted his error and agreed that it will not happen again. I do not think that a formal warning is appropriate to the scale of the case and I would recommend an informal warning, this has effectively already taken place as part of the process."[113]

74. The Inquiry considers it to have been inappropriate for Mr Brown to have included reference to his own personal experience of Mr O'Brien. Rather, the disciplinary report ought to have been based on the facts and information elicited by the investigation. The suggestion that the motivation for the incident was 'honourable' was misguided; it is a basic requirement for relevant information to be retained in the patient's chart. In response to questioning by Counsel to the Inquiry, Mr Brown reflected that:

"people who have a very good reputation clinically would be able to, to some extent, blind you a little bit for their shortcomings,"

and accepted that, to some extent, this had occurred with him in respect of Mr O'Brien.[114]

Delayed review of investigation results (2010)

75. In October 2010, a Serious Adverse Incident (SAI) investigation concerning Patient 95 concluded. The primary issue was the retention of a swab following surgery. The second issue was the delay in diagnosing this. Following surgery, the patient had a three-month follow up CT scan of the abdomen performed. Whilst the retained swab was not identified, the reporting Consultant Radiologist

113 TRU-278633
114 TRA-09135, lines 8-17

described a mass measuring 6.5cm in the right renal bed. However, this was not seen by the consultant urologist, Mr O'Brien, as it was his routine practice to review radiological and laboratory reports when the patient returned for post-operative follow up. In Patient 95's case, the planned four-month follow up appointment did not take place due to the waiting times for review at outpatients.[115]

76. In July 2011, an email from Ms Trouton asked Ms Corrigan and others to check with all consultants to ensure that, where investigations are requested:

> "the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them."[116]

Ms Corrigan forwarded Ms Trouton's email to the urology consultants on 27 July.[117] Mr O'Brien responded, expressing some concern and setting out 11 discrete queries about this expectation in an email addressed to Ms Corrigan, who had forwarded Ms Trouton's email. He wrote:

> "Martina,
>
> I write in response to email informing us that there is an expectation that investigative results and reports to be reviewed as soon as they become available, and that one does not wait until patients' review appointments. I presume that this relates to outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons:
>
> - Is the consultant to review all results and reports relating to patients under his / her care, irrespective of who requested the investigation(s), or only those requested by the consultant?

115 WIT-17478, paragraph 4
116 TRU-276807
117 TRU-276805 to TRU-276808

- Are all results or reports to be reviewed, irrespective of their normality or abnormality?
- Are they results or reports to be presented to the reviewer in paper or digital form?
- Who is responsible for presentation of results and reports for review?
- Will reports and results be presented with patients' charts for review?
- How much time will the exercise of presentation take?
- Are there other resource implications to presentation of results and reports for review?
- Is the consultant to report / communicate / inform following review of results and reports?
- What actions are to be taken in cases of abnormality?
- How much time will review take?
- Are there legal implications to this proposed action?

I believe that all of these issues need to be addressed,

Aidan." [118]

Ms Corrigan forwarded this to Mr Mackle who escalated this to Dr Rankin, characterising it as a governance issue.[119] Almost two weeks later, Dr Rankin expressed her concern that the issue had not yet been resolved "despite trying to have a conversation with Mr O'Brien."[120] Mr O'Brien told the Inquiry that he agreed with the principle but was concerned about "the practicalities" of this requirement.[121] The issue is discussed further in the Clinical Aspects and Governance chapters.

77. In November 2011, Dr Diane Corrigan (Consultant in Public Health Medicine) wrote to the Trust regarding the SAI concerning Patient 95. In her letter, she observed that the SAI report did not comment on, nor make any recommendation in relation to, the practice of the patient's consultant urologist not to review

118 TRU-276805
119 TRU-276804 to TRU-276805
120 TRU-276804
121 TRA-12471, lines 21-25

laboratory or radiology reports until patients attended their outpatient review. Dr Diane Corrigan queried whether there was a need for:

> "a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting outpatient review."[122]

78. Three years later, in September 2015, an SAI investigation concerning Patient 128 concluded.[123] One of the recommendations emerging from this report was that:

> "A mechanism must be put in place to ensure all radiology reports are seen, actioned and signed off by an appropriate person."[124]

Following this, in January 2016, Ms Trouton's personal secretary emailed all consultants on behalf of herself and Mr Mackle, the AMD responsible for urology to emphasise that:

> "it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed."[125]

79. The issue of actioning results is discussed further in the Clinical Aspects and Governance chapters. Despite Mr O'Brien's views about the practicalities of the requirement to check results it was nonetheless an important patient safety matter and all clinicians ought to have appreciated that.

Inappropriate storage of notes (2013)

80. In May 2013, Ms Helen Forde (Head of Health Records) raised a concern about a patient's chart having been found to be in Mr O'Brien's home.[126] The issue was

122 TRU-259901 to TRU-259902
123 TRU-100789 to TRU-100807
124 TRU-100800
125 TRU-277936; TRU-277943 to TRU-277944
126 WIT-98416

escalated to Ms Corrigan, Ms Anita Carroll (Assistant Director Functional Support Services (FSS)) and Mrs Deborah Burns (Director of Acute Services).[127] Ms Corrigan noted that "This has been an ongoing problem for years" and suggested that it may be necessary to involve Mr Brown (CD for Surgery and Elective Care).[128] It is unclear if Mr O'Brien was spoken to formally at this time, or if the CD became involved. What is, however, clear, is that the issue remained unresolved for too long.

81. In August 2013, a Health Records Manager observed that:

> "the problem is getting worse instead of better. … Last week was particularly bad".[129]

The issue was once again escalated to Ms Corrigan, Ms Carroll, Ms Trouton and Mrs Burns, who identified it as "a governance issue" and suggested Mr Brown discuss again with Mr O'Brien or that the matter be escalated. Ms Corrigan agreed to speak to Mr O'Brien again and to let Mr Brown follow up.[130] Despite this, the issue continued to present itself throughout the remainder of 2013.[131]

In November 2013 an incident was escalated to Ms Carroll who in turn raised it with Ms Trouton, Ms Corrigan and Mrs Burns saying:

> "Dear all I know we have discussed before and heather [sic] I know you met him Really don't know what we now do".[132]

Mrs Burns suggested escalation to Dr John Simpson (Medical Director).[133] Ms Trouton said she had spoken to both Mr O'Brien and Mr Young as CL for

127 WIT-98415
128 WIT-98415
129 WIT-11963 to WIT-11965
130 WIT-11963 to WIT-11965
131 WIT-11966 to WIT-11967; TRU-276837 to TRU-276838; TRU-276839 to TRU-276840
132 TRU-278121 to TRU-278122
133 TRU-278121; WIT-96916, paragraph 49.9

Urology and that "Mr O,Brien [sic] advised that he would cease this practice" and she suggested:

> "We could ask Mr Brown to discuss with him but I don't think it would have any effect."[134]

Ms Carroll agreed that escalation to Dr Simpson "might be worth a try" [135] but this was not followed up. More is said about this in the Medical Management and Leadership and Governance chapters. Essentially, we are of the view that Mr Mackle ought to have escalated the matter, but if he felt unable to do so then the Acute Director ought to have done so.

82. Still the practice continued. Between May 2013 and February 2014, 24 IR1s (incident report forms) had been submitted in respect of 54 patient charts.[136] The evidence demonstrates that Ms Carroll, Ms Trouton, Mr Mackle, Ms Corrigan and Mrs Burns were all aware of this figure at the time.[137] Any action taken by medical managers appears to have been ineffective as Mr O'Brien was still keeping patient notes at home eight months later.[138]

83. In January 2015 a patient, whose notes were believed to be at Mr O'Brien's house, attended the Emergency Department. Ms Corrigan, Ms Carroll and Ms Trouton were aware.[139] Ms Trouton emailed Mr Young to request his assistance:

> "As you know we have spoken to Aidan about this on a number of occasions. He brings his current charts in and then seems to start the process again.
>
> Would you see if you could find a way of asking him to manage this process a bit better.

134 TRU-278120; TRU-276904
135 WIT-98417
136 TRU-278656
137 TRU-278656
138 TRU-277892 to TRU-277893; TRU-274332 to TRU-274333; TRU-257247
139 TRU-277894

We do value all the hours he puts in, that is not the issue, but patient charts do need to be in the hospital for emergency and outpatient attendances."[140]

84. On 27 January 2015 Ms Carroll emailed Ms Trouton and Ms Corrigan asking:

"Do you think you ? [sic] Should have something on risk register in relation to this".[141]

Ms Trouton responded to say:

"I spoke to Mr Young about this last week and he is going to speak to Aidan again.

I will consider the Risk register although with that you are supposed to address the risk and eliminate it. This is down to a personal way of working which seems impossible to stop."[142]

More is said about this in the Clinical Aspects and Governance chapters.

85. It is clear that senior managers within the Trust were aware of Mr O'Brien's practice of keeping patient notes in his home. However, despite having properly identified this as a governance issue, its significance as a patient safety risk does not appear to have been sufficiently appreciated; had it been sufficiently appreciated, the issue would not have been allowed to continue for as long as it did. For example, it ought to have been appreciated that notes not being available to clinicians on the hospital site meant that patients who arrived at the emergency department were at risk from the absence of their notes. More is said about this in the Clinical Aspects and Governance chapters.

140 TRU-277894
141 TRU-277895
142 TRU-277895

86. It is difficult to understand why this issue – which had, by that time, been ongoing for years - would not have been escalated to the Medical Director in 2013, as had been suggested by Mrs Burns. It is more difficult still to understand why it would not have been so escalated in January 2015, rather than being referred back down the management line to the CL for yet another conversation with Mr O'Brien; an approach which had already been tried and had proven ineffective. On each occasion on which it became clear that Mr O'Brien was not changing his practice despite the issue having been discussed with him, the issue ought to have been escalated upwards.

87. The weak management response to this issue facilitated its continuation across a period of years. This sense of resignation by management demonstrates that the Trust's governance systems and culture were not in a healthy place and that there was a tolerance of ongoing risk to patient safety. It is indicative of poor governance and a culture that allowed poor practice to go unchecked. More is said about this in the Clinical Aspects and Governance chapters.

88. Criticism of the Trust does not absolve Mr O'Brien of personal responsibility; he should not have been keeping patient notes at home and certainly should not have continued to do so, having been asked not to. Doing so was contrary to the General Medical Council (GMC) standard that states that:

> "You should be familiar with, and follow, the confidentiality, data protection and record management policies and procedures where you work and know where to get advice on these issues."[143]

This is discussed further in the Clinical Aspects and Governance chapters, but Mr O'Brien's practice of keeping notes at home placed patients at risk.

143 INQ-30856, GMC Leadership and Management, paragraph 44; see also paragraph 41 on information governance generally

89. As will be seen later in this chapter, this issue was to become one of the 'MHPS concerns'. Indeed, it was not until the MHPS investigation started that the scale of this issue was identified.

Bicalutamide prescribing (2014)

90. Mr O'Brien's approach to the prescription of Bicalutamide, a recurring theme in the 2020 SAIs, is addressed in detail in the Clinical Aspects chapter. However, the Inquiry received evidence suggesting that this practice (prescribing Bicalutamide outside the relevant guidelines) had been ongoing for over a decade and demonstrating that clinicians in another Trust were not only aware but had concerns.[144]

91. Dr Darren Mitchell, a Clinical Oncologist attached to the Belfast Trust, recalled having been referred some prostate cancer patients by Mr O'Brien, who had been commenced on what he (Dr Mitchell) described as an "unlicensed dose" of Bicalutamide.[145] As Chair of the Regional Multidisciplinary Team (MDT), Dr Mitchell emailed Mr O'Brien in November 2014 about his prescribing outside recommended guidelines and highlighting that it was Mr O'Brien's professional duty as a clinician to inform patients that they were being treated outside those guidelines.[146] Dr Mitchell did not receive any response to this email from Mr O'Brien.[147]

92. In 2015, during Mr O'Brien's tenure as Chair, the Northern Ireland Cancer Network (NICaN) Urology Network was engaged in developing various regional

144 Professor O'Sullivan: WIT-96650, paragraph (x) and TRU-162262; Dr Mitchell: WIT-96666 and WIT-96819

145 WIT-96667: Dr Mitchell explained that the licensed doses for Bicalutamide are either 150mg once daily as monotherapy or 50mg once daily when used with Luteinising Hormone-Releasing Hormone (LHRH) agonists. He indicated that he was not aware of any licensed indications for Bicalutamide 50mg once daily as monotherapy (i.e. alone, without LHRH agonists). On this basis, Dr Mitchell considered the use of Bicalutamide 50mg once daily as monotherapy as being outside the licensed indications.

146 WIT-96677

147 WIT-96671, paragraphs 4(i) and 4(iii)

clinical management guidelines.[148] Dr Mitchell wrote the androgen deprivation guidelines.[149] He explained that his intention in drafting the guidelines was to:

> "standardise the prescription of hormone therapy and stop the use of off licence Bicalutamide 50mg monotherapy".[150]

He explained that these were "in large part" written to address concerns about Mr O'Brien's approach to prescribing Bicalutamide.[151] He told the Inquiry that:

> "This approach was taken in the knowledge that Mr O'Brien would be required to formally review and accept the guidelines in his role as NICAN Chair."[152]

However, he was not aware if Mr O'Brien ever formally approved the guidelines.[153] Dr Mitchell explained:

> "These guidelines could have been audited within each trust. If my belief that Mr O'Brien was the only person in the region using Bicalutamide 50mg monotherapy is correct then it would in essence have been an audit of his hormone therapy prescriptions in the southern trust. The guidelines were written to encourage good practice and provide a point of reference if there were future cases identified with this off-licence prescribing."[154]

93. Unfortunately, while this issue was highlighted in 2014 it was not addressed in the Trust until 2019/2020.[155] Dr Mitchell accepted that he ought to have discussed his concern formally with his CD at the time, making it clear that he was doing so.[156] There was clearly a lack of clarity as to what path ought to have been taken by Dr Mitchell given that he was practicing in a different Trust. The

148 WIT-96683 to WIT-96684
149 TRU-162276; WIT-96667, paragraph 1(ii)(b)
150 WIT-96669, paragraph 1(ix)
151 WIT-96669, paragraph 2(i)
152 WIT-96670, paragraph 2(ii)
153 WIT-96670, paragraph 2(iv)
154 WIT-96670, paragraph 2(iii)
155 WIT-96671
156 TRA-07780, lines 9-10

Inquiry recommends that the Department of Health (the Department) consider devising a clear mechanism whereby concerns can be raised inter Trust, possibly by directly contacting a clinician's responsible officer. This is all the more important as patients are increasingly receiving treatment outside their own Trust.

94. Equally however, if the Trust had engaged in regularly auditing guidelines the practice would have been clearly identified and addressed sooner.

Triage (1996)

95. Triage refers to the necessity for a referral letter, whether from a GP or other professional, to be looked at to ensure that the case has been correctly identified as either Routine, Urgent, or Red Flag. Once triaged, the patient is added to the appropriate waiting list to be seen. It is apparent that timely triage had been an issue for Mr O'Brien for a considerable number of years.[157] Mr Mackle described Mr O'Brien's triaging practice as "an ongoing problem" and recalled having to speak to Mr O'Brien about it in or around 1996.[158] Mr Mackle explained that "Intermittently over the years it would be noted that he was behind on triage" but observed that "when challenged, [he] would catch up."[159] The evidence the Inquiry has seen tends to corroborate this observation.

96. The Trust's Integrated Elective Access Protocol (IEAP) – issued in April 2008 – set expectations as to how, and the timeframes in which, referrals were to be managed.[160] In December 2008, Ms Teresa Cunningham, (Emergency Planning Manager) emailed Mr Simon Gibson (Assistant Director) and Mr Mackle, in plain terms, setting out the difficulties caused by Mr O'Brien's failure to triage in a timely manner:

157 WIT-11815, paragraph 210; WIT-51687, paragraph 1.22
158 WIT-11784, paragraph 128; WIT-11815, paragraph 210
159 WIT-11784, paragraph 128
160 TRU-00840 to TRU-00845

> "the current situation is intolerable. … The service is not manageable under these circumstances and I feel I can not continue to manage it unless this issue is properly addressed. If Mr O'Brien is constantly facing difficulties triaging his referrals within the timeframes specified within the IEAP, then we need to put something else in place to facilitate the smooth operation of the service and to ensure that we can offer patients reasonable notice."[161]

97. Things did not improve.[162] When Dr Rankin came into post on 01 December 2009 it was an issue.[163] In April 2011, 129 untriaged letters were identified in Mr O'Brien's office, of which Mr Young triaged 14 and Mr Mehmood Akhtar triaged 53. Concerningly, an internal Trust note recorded that 62 letters were still to be triaged by Mr O'Brien and that, of those triaged by Mr Young and Mr Akhtar, nine were upgraded to Red Flag.[164]

98. By November 2013, the Booking and Contact Centre Manager was flagging a list of 104 letters which needed triage by Mr O'Brien.[165] Ms Trouton emailed Mr Young and Mr Brown seeking a response within one week indicating how the issue would be addressed and indicating that the issue may need to be escalated to the Medical Director "unless a sustainable solution can be found."[166] Mr Young responded to indicate that he would speak to Mr O'Brien, whereas Mr Brown replied:

> "I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind. … Aidan is an excellent surgeon and I'd be more than happy to be his patient … so I would prefer the approach to be "How can we help"."[167]

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161 WIT-23742
162 AOB-00131; AOB-00133; TRU-281814; WIT-11815, paragraph 212; WIT-11816, paragraph 212; WIT-51815, paragraph 63.4
163 See paragraph 63 above
164 TRU-281926
165 TRU-276843 had an attachment which contained 104 patients' names and details, awaiting triage; TRU-276905
166 TRU-276904
167 WIT-98423

99. In December 2013, following a conversation with Mr Brown, Ms Trouton advised Mr Young:

> "the only solution we see if it is unlikely that Aidan will change practice is for triage to no longer go to him. I appreciate this will put an increased burden on yourself, Tony [Mr Anthony Glackin] and Mr Surresh [sic] but it is just too critical to leave as it is."[168]

Despite Mr Young protesting that this was not "acceptable", this 'solution' was ultimately adopted by the Trust.[169] It was not a solution. It was unfair that the other consultant urologists should have been asked to bear an increased workload to cover Mr O'Brien's failure to triage as expected and this should not have been asked of them. This was not a sustainable solution but rather, in effect, a failure to take joint operational and medical management responsibility for a significant issue impacting on patient safety. Mr O'Brien's ongoing failure to triage should have been escalated to the Medical Director if the Acute Directorate felt unable to resolve the problem.

100. Mr Young told the Inquiry that this was not the first time he had covered Mr O'Brien's triage, describing a six-month period in 2013. Ms Corrigan told us of a further period in early 2014 where he had done so.[170] Mr O'Brien observed that this arrangement:

> "was not only temporary but failed to address the underlying cause, which was progressively exacerbated by the additional burden of my roles with NICaN and with the Trust's Urology MDT and MDM at that time."[171]

The Inquiry agrees that this did fail to address the 'underlying cause' or the actual issue; namely, Mr O'Brien's failure to triage in accordance with the Trust's expectations, which the other consultants were able to comply with.

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168 WIT-11954
169 TRU-282020; WIT-11954
170 WIT-51815, paragraph 64.1; TRA-07325; TRA-07328; TRA-07337
171 WIT-82562, paragraph 469

101. Moreover, while it is important that clinicians take on medical leadership roles, be it in NICaN, heading up an MDT, acting as CD or Medical Director, these roles are burdensome. While in more recent years there has been a concerted effort to allocate more time to the roles it is nonetheless incumbent on the clinician to manage the basic patient care requirements of practice such as triage and dictation of letters. Clearly Mr O'Brien, unlike Mr Mark Haynes as AMD, was unable or unwilling to adapt his practice to fulfil both roles. He should not have accepted the NICaN role and the Trust ought to have directed his efforts elsewhere, both for his good and the good of his patients.

102. A strong medical management structure is necessary to provide support and mentorship for those willing to take on leadership roles. More is said about this in the Medical Management and Leadership chapter.

103. It is clear that at this point Mr O'Brien was a doctor in difficulty and should have been managed as such, with a formal plan of support and action. Mr Brown's instinct of 'how can we help' was the right one but this was not carried through to a point where he was able to direct Mr O'Brien in a programme of change. The Inquiry recognises that there are times when colleagues need to cover the work of others, due to physical or mental illness. In this case, which did not involve a colleague's illness, no one grasped the problem at any level of medical leadership. Tackling it should have had support from Human Resources (HR), if necessary, and followed a formal procedure for dealing with doctors in difficulty. The actions taken were not logical and did a disservice to patients, Mr O'Brien and the other urologists. How this was handled demonstrates both a cultural failure and a failure of medical management and leadership.

104. The Inquiry heard that, when the Urologist of the Week (UoW) model was introduced in or around 2014, the consultants believed that this would not be the busiest of weeks for them and, therefore, they agreed that they could do triage

during their turn as UoW.[172] Whilst all of the other consultant urologists managed to complete their triage as UoW, whether during the week itself or across the days immediately following it, Mr O'Brien could not do so.[173] He told the Inquiry that he always triaged Red Flag referrals and those Urgent and Routine cases that he had time to do.[174] This resulted in a substantial backlog of untriaged referrals from his week as UoW.[175]

105. It is the Inquiry's view that the reason Mr O'Brien was unable to complete triage was because of his desire to do triage his way. Mr O'Brien's method was essentially a virtual outpatient appointment with Mr O'Brien ordering tests and investigations after speaking to the patient by telephone. It is the considered view of the Inquiry that this was not what was expected. Whilst it might be argued that those patients who were triaged in this way received superior service, it meant that many others got no service at all because their referral was not triaged.[176]

106. The dangers of not triaging referrals are self-evident; there is the risk that the patient can be lost and not added to the waiting lists, but more importantly, failure to triage increases the risk of late diagnosis and treatment. Sadly, this proved to be the case in respect of some patients, who at the material time had undiagnosed cancer. Patients 11, 12, 13, 14 and 15, who each went on to develop cancer in circumstances where their referrals – had they been looked at – would have led to an escalation to Red Flag.[177]

107. Knowing that Mr O'Brien and others were behind with triage, what has been described as an 'initial default triage' system was set up some time in 2014.[178] In essence, this was to operate as a failsafe mechanism whereby, if a referral letter was not triaged by a consultant, the patient was added to the waiting list in

172 TRA-04653, lines 10-16
173 TRA-12248, lines 15-17
174 WIT-82558; WIT-82566; WIT-82593
175 TRU-274672
176 TRA-00861
177 See Patients and Clinical Aspects chapters
178 TRU-277196; TRU-277494; WIT-11785, paragraph 129; WIT-51824 to WIT-51825, paragraph 66.3

accordance with the designation on the referral letter.[179] In this way, the risk of patients becoming entirely lost to the system was addressed; once triaged, the patient could then be moved onto the appropriate waiting list. However, this was only effective if the delay in triage was short. It did not take account of a lengthy delay in triaging, an issue for patients whose letters were to be triaged by Mr O'Brien, where the patient remained on a potentially incorrect waiting list.

108. In any event, it appears that Mr O'Brien continued to have significant difficulty in performing the triage which remained his responsibility (referrals addressed specifically to him) and that managers within the service were regularly seeking to get this issue addressed.[180] By 20 November 2014, there were 206 triage letters outstanding in the urology service.[181] Almost one year later, on 30 November 2015, there were 277 untriaged letters from when Mr O'Brien was UoW, the longest of which dated back 58 weeks to October 2014.[182] The issue persisted into 2016 and, as discussed in greater detail later in this chapter, would become one of the 'MHPS concerns'.[183]

109. Mr Mackle acknowledged that Mr O'Brien's delay in triaging "allowed a significant governance risk to arise" and conceded that:

> "a potential risk to patient safety … was not, in my view, properly appreciated at the time)".[184]

The Inquiry agrees. More is said about this in the Clinical Aspects and Governance chapters. The issue of triage clearly demonstrated the cultural problems within the Trust and the failure of overall governance.

179 WIT-11785, paragraph 129
180 AOB-00679; TRU-277443; TRU-277494; TRU-277623; TRU-277836
181 TRU-274344
182 TRU-258498
183 TRU-258501; TRU-258509 to TRU-258510; TRU-282022 to TRU-282024
184 WIT-11785, paragraph 129; WIT-11817, paragraph 218

Undictated clinics (2015)

110. In October 2015, an IR1 was filed which noted that a letter had been received from a patient's GP, highlighting that the patient had been reviewed by Mr O'Brien on 28 November 2014. The necessary referral for radiotherapy, which would normally be listed on an outcome sheet, had not been made.[185] A further missing outcome was identified the following month.[186] It was suggested that Mr O'Brien did not use the clinic outcome sheet.[187] Mr Young characterised the outcome sheet as "an integral part of the clinic process".[188] He referred to further examples of delayed or undictated letters for over six months, indicating that this:

> "interrupted clinicians' understanding of the patient's planned care pathway in late 2015 and in August 2016."[189]

Mr Young indicated that he, and the other urology consultants, raised this issue.[190]

111. Mr Young summarised the significance of the issue:

> "Undictated correspondence following a clinic appointment is a risk from the perspective that other clinicians may not know the outcome of a consultation. This would be the case for a GP as they would not have access to the chart. … Without the return of 'Outcome Sheet', the secretary would also not know how to process the patient when the letter is undictated. I believe Mr O'Brien had liked to dictate after the completion of the patient journey. This, however, missed opportunities for other clinicians to be kept informed in-between times. At several unspecified and un-minuted Departmental meetings, this had been

185 TRU-277905
186 TRU-258492 to TRU-258493; WIT-51819, paragraph 64.11
187 TRU-258493; WIT-51819, paragraph 64.11.
188 WIT-51819, paragraph 64.11
189 WIT-51819, paragraph 64.11
190 See for example evidence of Mr Haynes at TRA-00865; WIT-54882; and Mr Young at TRA-09646 to TRA-09648

raised with and without Mr O'Brien's presence. The secretarial management would have been aware of these points."[191]

112. It is normal practice following interaction with a patient that, in addition to making notes on a patient file, a letter is dictated to the patient's GP (and sometimes to the patient directly) setting out, for example, what the examination had shown or the treatment plan. This not only informs the GP about the patient's condition but, also, provides a record for any subsequent treating clinician. This presented difficulties for clinicians who were dealing with emergency admissions or where patient care was transferred to another clinician.[192] The Inquiry understands that such dictation does not require to be lengthy but should include a basic account of the consultation and be added to the written note which GMP suggests should include:

> "a relevant clinical findings
> b the decisions made and actions agreed, and who is making the decisions and agreeing the actions,
> c the information given to patients
> d any drugs prescribed or other investigation or treatment
> e who is making the record and when."[193]

113. The GMC's GMP document requires that clinicians must make sure that formal records of their work are clear, accurate, and legible and made at the same time as the events being recorded or as soon as possible afterwards. GMP is an ethical framework that carefully sets out what 'must' be done by doctors and what 'should' be done by them. The requirements around contemporaneous notes are mandatory but the content, outlined above, is a guidance as to what ought to be included in practice, a short, well-constructed letter is often easier to understand than patient notes.

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191 WIT-51826 to WIT-51827, paragraph 67.4
192 See evidence of Mr Haynes at WIT-53936, paragraph 62.4 and of Mr Glackin set out in the Clinical Aspects chapter, paragraphs 301 and 427
193 INQ-30877, paragraph 21, GMC Good Medical Practice, Domain 1

114. The Inquiry heard that most clinicians did dictation at the end of a clinic.[194] Mr O'Brien accepted that he did not always dictate after outpatient clinics but told the Inquiry that he was not aware that there was any expectation that dictation should be done at the end of each consultation.[195] Whilst Mr O'Brien accepted that non-dictation after clinics and day procedures was sub-optimal and could have impacted on patient safety, he told the Inquiry that he had:

> "taken every measure to mitigate this risk by identifying and prioritising urgent cases requiring a prompt transfer of information. It was the responsibility of the Trust to assess this risk and to devise a system whereby I had sufficient time to cope with the excessive administrative demands placed upon me."[196]

The Inquiry has seen many lengthy letters dictated by Mr O'Brien and can readily understand that these would have required a considerable amount of time. If Mr O'Brien had been prepared to engage in the same sort of dictation as his colleagues, the time he required to do this task would have been considerably less. Issues with Mr O'Brien's dictation practices persisted and ultimately became one of the 'MHPS concerns'.[197]

Private patients (2015)

115. In May 2015, in response to an email about the urology waiting list, Mr Haynes emailed Mr Young and Ms Corrigan to say:

> "I feel increasing uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non NHS clinic. …The immorality of this is astounding and yet this is far from an isolated event, indeed I recognise it every time I am on the wards and discussing with various members of the team it is 'accepted' as normal practice. … This behavior

194 TRA-03837; TRA-08902 to TRA-08903; TRA-09498 to TRA-09500; TRA-09578; TRA-09645
195 TRA-04739, lines 17-27
196 WIT-82589, paragraph 557
197 See paragraph 233 below and Clinical Aspects chapter

needs to challenged a stop put to it [sic]. … I would suggest that this needs challenging by a retrospective audit".[198]

Mr Young responded the same day, acknowledging that Mr Haynes' observations were valid.[199] However, no audit was undertaken.[200] Mr Young conceded that he had missed the reference to the need for an audit:

"the ball was dropped on this one. It was a word used in the middle of a long e-mail. I probably should have had a look at it in more detail at that time."[201]

116. The practice continued, unchallenged, and, in November 2015, Mr Haynes again raised this concern with Mr Young and Ms Corrigan by way of an email entitled 'Queue Jumpers' and identified two examples of patients seen at Mr O'Brien's home who were:

"private patients being brought onto NHS lists having significantly jumped the Waiting List."[202]

Mr Haynes expressed his concern and apparent frustration in stark terms, stating:

"This is Immoral [sic] and unacceptable. … Can you advise me what action has been taken since I raised this?"[203]

Mr Young responded to indicate that he had:

198 WIT-54107
199 TRU-274504
200 TRA-00899, line 16 to TRA-00900, line 2; TRA-09657, lines 16-19; WIT-26267, paragraph 54.1(ix)
201 TRA-09658, lines 10-13
202 WIT-54106
203 WIT-54106

> "spoken before to the person in question re this issue in general and the justification of urgency – and I agree since the waiting list for some things are so long eg urodynamics.
> Will have to speak again then".[204]

117. Mr Young recalled having spoken to Mr O'Brien about the concern but accepted that he ought to have done more by way of follow up and, specifically, ought to have escalated the second email to more senior managers.[205] He reflected that, on both occasions, "this issue simply got side-lined because of other more pressing day-to-day work."[206] In his evidence to the Inquiry Mr O'Brien was emphatic that Mr Young never raised this issue with him at that time.[207] Regardless of whether he discussed this issue with Mr O'Brien, a concern being raised by a Consultant colleague in these terms should have prompted Mr Young to escalate the issue. He failed to do so on both occasions. Mr Haynes could not have expressed his concern more clearly. If the first did not, his second email in November certainly ought to have prompted further escalation and, at the very least, some documented further enquiry by Mr Young. As Mr Mackle, the AMD at the time, told the Inquiry:

> "If he [Mr Young] dealt with it in June and it was still happening, then it hadn't been resolved, therefore he needed to escalate even further and I would have said that was something I would have taken on myself."[208]

The Inquiry agrees. Mr Young should have escalated this issue to the AMD at the time. As will be seen later in this chapter, this would become one of the 'MHPS concerns' in 2016.

204 TRU-270116
205 TRA-09657, lines 9-15; TRA-09658, line 18 to TRA-09659, line 3; WIT-104216, paragraph 5b amending WIT-51820, paragraph 64.15
206 WIT-104216 to WIT-104217, paragraph 5b amending WIT-51820, paragraph 64.15
207 TRA-04742, line 28 to TRA-04744, line 29
208 TRA-02238, lines 5-8

Conclusions

118. Concerns about various aspects of Mr O'Brien's practice, which should have given rise to concerns for patient safety, had been known about for many years. These issues were not addressed effectively by management within the Trust, particularly those in the medical management line. Whilst each of the issues set out above have different features, in almost every case the managerial response was characterised by delay, inconsistency, an absence of escalation, a tolerance of non-compliance and the adoption of 'workarounds' which enshrined poor performance and jeopardised patient safety. This was a failure of governance in its broadest sense. More is said about this in the Governance chapter.

119. The Trust should have addressed the concerns earlier and more effectively. It should have used the tools of what might be regarded as normal medical management, such as audit and data metrics, set in a clear framework for managing concerns and emphasising the importance of patient safety and of supporting doctors to improve.

120. The Inquiry notes that since it commenced its work, the Trust has developed programmes to support the understanding of medical and operational managers, so that the various mechanisms for resolving problems relating to the conduct and performance of doctors can be addressed more effectively. Medical and operational managers should both be involved in identifying issues and working together to resolve them rather than operating along professional silos.

121. There was a failure to recognise that issues characterised as administrative had the potential to be a patient safety risk. The Board has a role in emphasising the primacy of patient safety and the medical director and other medical leaders must also understand their role in protecting safe, effective patient care over and above the personal interests and confidentiality of doctors.

122. What occurred prior to 2016 demonstrates management repeatedly trying to work around what were perceived to be Mr O'Brien's idiosyncrasies, partially due

to the pressures in the service generally. When the medical director did become involved, greater progress was made, for example in respect of the IV antibiotics.

123. Where simple normal medical management is ineffective, then MHPS ought to be triggered, and the Medical and HR directors should provide guidance and advice at an early stage especially for less experienced medical and operational managers. More is said about this in the Governance chapter.

124. Overall, prior to 2016, the Trust failed to avail of the processes which were available to identify, challenge and correct poor standards of professional practice.

Investigation of concerns in 2016

125. Concerns relating to Mr O'Brien's practice, particularly with regard to triaging, record-keeping and the storage of notes, had been known about for a number of years. Despite this, prior to 2016, the Trust did not undertake any structured or meaningful investigation of Mr O'Brien's practice. Rather, as demonstrated in the preceding section of this chapter, these issues were raised and addressed with Mr O'Brien on an ad hoc basis. This changed in 2016, when the MHPS Framework was used to investigate concerns relating to Mr O'Brien's practice.

126. The Inquiry's task, in accordance with Term of Reference (e) is:

> "To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy."

127. The remainder of this chapter considers the evidence received by the Inquiry in relation to how the MHPS Framework was used in respect of Mr O'Brien; whether

it was appropriate to use the MHPS Framework to address the concerns regarding Mr O'Brien; whether it could, or should, have been used at an earlier stage; the circumstances surrounding the decision to use the MHPS Framework; the implementation of the process and whether it was effective in addressing the performance issues identified.

The MHPS Framework

Introduction, purpose and aims

128. Maintaining High Professional Standards in the Modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS (the MHPS Framework) was published in 2005 by the then Department of Health, Social Services and Public Safety (DHSSPS).[209] It is a framework for "handling concerns about the conduct, clinical performance and health" of doctors and dentists employed in the Health and Social Care system (HSC)[210] and covers:

> "action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice."[211]

It was modelled on the Maintaining High Professional Standards in the Modern NHS policy, which had been issued by the Department of Health in England in 2003.[212]

129. The MHPS Framework was introduced as there had:

> "been some concern in the past about the way in which complaints about doctors and dentists have been handled."[213]

209 TRU-292402 to TRU-292449
210 TRU-292406, paragraph 1
211 TRU-292406, paragraph 1
212 Maintaining High Professional Standards in the Modern NHS: INQ-30001 to INQ-30059
213 TRU-292406, paragraph 6

In particular, concerns had been raised about the use of suspension, with the equivalent Framework in England (Maintaining High Professional Standards in the Modern NHS) noting that:

> "The number of doctors and dentists who have been suspended from work for long periods is a cause for concern. Although the numbers are small the costs to the NHS are substantial."[214]

130. The MHPS Framework was, therefore, designed to focus on improvement when issues relating to a practitioner's practice and requiring investigation were identified; exclusion from work was only to be used in the most exceptional circumstances.[215] This remedial approach had the dual benefit of enabling a doctor to continue to practice, and thereby maintain their skillset, whilst ensuring that the employer was not deprived of a medical professional.[216] Importantly, however, the MHPS Framework itself makes clear that, whilst the new approach recognises the importance of seeking to address clinical performance issues through remedial action (rather than solely through disciplinary action):

> "it is not intended to weaken accountability or avoid disciplinary action where the situation warrants this approach."[217]

131. The MHPS Framework took effect from 01 December 2005[218] and remains in force at the time of writing. Both the Framework and its operation have been subject to criticism in other public inquiries, most recently by the Independent Neurology Inquiry (INI), which reported in June 2022.[219] That Inquiry was concerned that the requirement for confidentiality, enshrined in paragraph 39 of the MHPS Framework, gave rise to a risk that patient safety concerns would be compromised. It issued three recommendations aimed at addressing that issue:

214 Maintaining High Professional Standards in the Modern NHS, paragraph 1: INQ-30004
215 TRU-292407 to TRU-292408, paragraph 10
216 TRU-292407, paragraph 8
217 TRU-292407, paragraph 9
218 WIT-43523 to WIT-43525
219 INQ-10730

"(16) The NI Department of Health should ensure that the confidentiality dimension of the MHPS process is always subordinate to patient safety considerations.

(17) The NI Department of Health should review paragraph 39 of MHPS and issue guidance on the appropriate balance between confidentiality for the clinician and safety for the patients.

(18) The NI Department of Health should oversee the establishment of a group to consider the balance between the fair treatment of clinicians and the safety of patients under MHPS. The group should focus on reducing the complexity of processes and re-evaluating the degree of confidentiality. The group would benefit from input from appropriate experts to include Human Resource expertise and Medical Directors."[220]

132. However, despite the Department having initiated reviews of the Framework in 2009 (just four years after its implementation) and 2018, it has not been updated since its introduction.[221] For a variety of reasons set out in Mr Peter May's witness statement referred to later in this chapter, neither of those reviews were completed.[222]

133. More recently, in May 2023, the Department established an Independent Review Panel to examine the application and effectiveness of MHPS.[223] Its final report, *Review of Maintaining High Professional Standards in Northern Ireland*, was published in July 2024.[224] In that report, the Review Panel acknowledged that "a substantive review of the MHPS policy is overdue" and concluded that the current MHPS Framework "is no longer fit for purpose".[225] The Review Panel made 24 recommendations in respect of the MHPS Framework.[226] These are discussed further in the Recommendations section below.

220 See INQ-10767 of the INI Report at INQ-10730 to INQ-10971
221 DOH-72564 to DOH-72702, Appendix F.1; TRA-00746, lines 7-9
222 TRA-00746, lines 7-9
223 DOH-72564 to DOH-72702
224 DOH-72564 to DOH-72702
225 DOH-72564 to DOH-72702, page 13, paragraph 1.2.1 and Conclusion, page 64
226 DOH-72564 to DOH-72702, pages 68-74

Implementation of the MHPS Framework within the Trust

134. The MHPS Framework only applies to doctors or dentists employed in the HSC. It does not apply to any other clinician. Its purpose is to support other employment processes; it is not designed to be the primary tool for the resolution of issues but, rather, to be used when normal medical management systems have failed to resolve them. The MHPS Framework document explains that HSC bodies must have their own internal procedures for handling concerns which:

> "must reflect the framework … and allow for informal resolution of problems where deemed appropriate."[227]

The tools available to management and their use are discussed in greater detail in the Governance and Medical Management and Leadership chapters.

135. In relation to advice and support on the MHPS Framework, a circular attaching the Framework was sent to HSC bodies by DHSSPS on 30 November 2005, which explained that MHPS superseded specified pre-existing guidance.[228] Stakeholders were directed to notify DHSSPS of the action they had taken to comply with the Framework by 31 January 2006.[229] However, neither the Trust nor the Department were able to provide the Inquiry with copies of this notification.[230]

136. Ms Vivienne Toal, Director of Human Resources & Organisational Development (HROD) in the Trust, confirmed that there were initially no local guidelines in the 'Legacy Trust'[231] or in the Trust.[232] It was not until 23 September 2010, some five

227 TRU-292408, paragraph 11
228 WIT-43523 to WIT-43525
229 WIT-43525. See also MA v BHSCT [2008] NIQB 143, paragraph 46 at INQ-20030 to INQ-20056. Article 17(1) of the Health and Social Services (NI) Order 1972 gives the Department of Health the power to make directions. Under the Health and Personal Social Services (NI) Order 1991 Schedule 3, Paragraph II Paragraph 6(2) "An HSS Trust shall comply with any directions given to it by the Department about the exercise of the Trust's functions."
230 WIT-57941: WIT-57979; WIT-42372. The Inquiry notes that this predates the use of TRIM or Content manager by the NICS.
231 The predecessor to the Southern Trust, the Craigavon Area Hospitals Group Trust: TRA-03291
232 TRA-03304, lines 5-12

years after the Departmental direction, that the Trust issued its own internal procedure in the form of the "Trust Guidelines for Handling Concerns about Doctors' and Dentists' performance" (the 2010 Guidelines).[233] Plainly, this should have been in place much sooner. Ms Toal, who had a role in the development of the 2010 Guidelines, told the Inquiry that, whilst NCAS had provided advice, no legal advice was obtained prior to the finalisation of the 2010 Guidelines. She accepted that legal advice should have been sought. [234]

137. The 2010 Guidelines complement the MHPS Framework and establish:

> "clear processes for how the Southern Health & Social Care Trust will handle concerns about it's [sic] doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation."[235]

As Ms Toal explained to the Inquiry, they were intended to "sit alongside and be read in conjunction with" MHPS[236] and:

> "Their purpose was to set MHPS as a framework into the Southern HSC Trust context in terms of clarification of who fills which roles within the Trust, … It was never the intention to replace MHPS with the Trust guidelines."[237]

138. The Trust Guidelines were updated in October 2017.[238] Ms Toal explained that this came about as a result of the Trust's:

> "reflections on the case involving Mr O'Brien, and in particular the difficulties at the early stages of the process involving the oversight group, which had led to confusion about roles and responsibilities in the management of the concerns."[239]

233 TRU-83685 to TRU-83702
234 WIT-41033, paragraph 7(xi)
235 TRU-83686, paragraph 1.5 of the Guidelines
236 WIT-41033, paragraph 7(x); TRA-03313, lines 17-18
237 WIT-41033, paragraph 7(x)
238 TRU-21031 to TRU-21049
239 TRA-03305 to TRA-03309; WIT-41046, paragraph 7(xiii)

This issue, and the subsequent amendment of the Guidelines, are considered further in paragraph 329 below. The Trust's decision to update its guidelines as a result of the experience of dealing with the MHPS investigation represents good practice and was a positive development.

Characteristics of an 'MHPS' investigation in the Trust

139. The 2010 Guidelines were formulated to provide a specific and practical explanation of how the MHPS Framework should operate within the Trust. In seeking to understand how an MHPS investigation operates within the Trust, it is, therefore, necessary to look at both the MHPS Framework and the 2010 Guidelines. This section provides a high-level overview of the procedure for an 'MHPS investigation' in the Trust, taking account of both the Framework and the Guidelines.

Key individuals

140. The MHPS Framework attempts to define the roles and responsibilities of a number of key individuals and post-holders,[240] including:

a. The Board of the HSC organisation
b. A Designated Board Member appointed to "ensure that momentum is maintained"
c. The Chief Executive, with whom "**all** concerns must be registered"
d. The Case Manager, "who will lead the formal investigation."
e. The Case Investigator, "who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager."
f. The HR Director
g. The National Clinical Assessment Service (NCAS).[241]

240 TRU-292402 to TRU-292449
241 Since 2013 NCAS has been known as 'Practitioner Performance Advice' (PPA)

141. Another important individual is the Clinical Manager. The 2010 Guidelines define the Clinical Manager as:

> "the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director)."[242]

Stage 1: preliminary enquiries/screening process

142. The first stage envisaged by the MHPS Framework is 'preliminary enquiries':

> "The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary."[243]

143. Whilst the MHPS Framework places great weight on quickly establishing the facts and utilising informal approaches, there is relatively limited substantive guidance about how this should be approached in the document itself. The only other guidance under this cross-heading in the MHPS Framework is a reminder that:

> "The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based

242 TRU-83701, Appendix 6 to the 2010 Guidelines
243 TRU-292413, paragraph 15

and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure."[244]

It states that, at this stage:

"consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner." [245]

This can be agreed within the Trust or, in the absence of agreement, can be referred for an NCAS assessment.

144. The 2010 Guidelines introduce further terminology at this stage of the process, referring to the need for concerns to "go through a screening process" when they are first identified.[246] Broadly speaking, the screening process is substantively identical to the 'preliminary enquiries' phase under the MHPS Framework.

145. The 2010 Guidelines further refer to the need for the Clinical Manager to:

"immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding."[247]

The 2010 Guidelines provide no further or substantive guidance on the steps a Clinical Manager should take in conducting this verification exercise. However, they do indicate that it is for the Clinical Manager and HR Case Manager to investigate concerns and assess what, if any, action should be taken. Possible actions at this point could include: no further action; informal remedial action with the assistance of NCAS; a formal investigation; or exclusion/restriction.[248] The

244 TRU-292413, paragraph 16
245 TRU-292413, paragraph 17
246 TRU-83688, paragraph 2.1
247 TRU-83688, paragraph 2.4
248 TRU-83689, paragraph 2.6.

policy is clear that any actions and decisions taken should be taken by the Clinical Manager and the nominated HR Case Manager together.[249]

146. The 2010 Guidelines also make provision for an Oversight Group, comprising the Medical Director, Director of HR and the relevant Operational Director.[250] The Clinical Manager and the HR Case Manager will come to a view and notify their "informal assessment and decision"[251] to the Oversight Group, who will then:

> "quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification."[252]

It is therefore clear that, rather than being a decision-making body itself, the role of the Oversight Group is to 'quality assure' the decision of the Clinical Manager and "to ensure consistency of approach in respect of the Trust's handling of concerns."[253]

Stage 2: the informal process

147. Where it has been determined that the issue of concern should be dealt with by an informal process, the Clinical Manager:

> "must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner."[254]

148. Where a workable remedial action plan cannot be agreed, the Clinical Manager, Operational Director and Medical Director should seek the:

249 TRU-83688, paragraph 2.4; TRU-83689, paragraph 2.6; TRU-83692
250 TRU-83688 to TRU-83689, paragraph 2.5
251 TRU-83689, paragraph 2.8
252 TRU-83689 to TRU-83690, paragraph 2.8
253 TRU-83701, Appendix 6
254 TRU-83693, Appendix 1

> "agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment."[255]

An informal plan may then be agreed and implemented with the practitioner.

149. In this phase, the Clinical Manager "monitors and provides regular feedback to the Oversight Group regarding compliance."[256] Where a practitioner fails to engage with the informal process, for example by failing to comply with the local action plan, management will move to the formal process.[257]

150. This section of the MHPS Framework also makes provision for immediate exclusion or restrictions:

> "When significant issues relating to performance are identified which may affect patient safety".[258]

In such circumstances:

> "the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice" such as: "to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace."[259]

The Framework emphasises the importance of consulting with NCAS prior to excluding a practitioner. Any such exclusion is limited to a maximum of four weeks, before the provisions of Section II of the Framework come into effect. The four-week period "should be used to carry out a preliminary situation analysis" and at the end of the period a "case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources."

255 TRU-83693, Appendix 1
256 TRU-83693, Appendix 1
257 TRU-83693, Appendix 1
258 TRU-292414, Section I, paragraph 18
259 TRU-292414, Section I, paragraph 18

should be convened.[260] Additional guidance is provided regarding the functioning of a case conference; if a Case Investigator has been appointed they will provide a preliminary report which the Case Manager will consider and decide whether "there is a case to answer" before considering whether an extended formal exclusion under Section II is required.[261]

Stage 3: the formal process

151. Once an HSC body has made a decision to initiate a formal approach, it is for the Chief Executive, following discussion with the Medical Director and Director of HR, to appoint a Case Manager, Case Investigator and ensure that the Chair appoints a Designated Board Member.[262] The MHPS Framework states that:

> "All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' [sic] costs and resulting action."[263]

The Trust conceded that there had been no such formalised audit process.[264] In the absence of such an audit mechanism, senior executives within the Trust could not be provided with assurance regarding the progress, cost and actions of processes initiated under the MHPS Framework. That was clearly unacceptable.

152. The MHPS Framework is not prescriptive about the way in which a formal investigation should be conducted, but it does prescribe a series of onerous timeframes:

260 TRU-292414, Section I, paragraph 20
261 TRU-292420, Section II, paragraph 10
262 TRU-292415, Section I, paragraph 28
263 TRU-292415, Section I, paragraph 29
264 WIT-57954, paragraph 8.1

4 weeks (from appointment of Case Investigator) – Case Investigator to complete investigation, except for in "exceptional circumstances".[265]

5 working days thereafter – Case Investigator submits report to Case Manager.[266]

10 working days thereafter – Case Manager gives the practitioner the opportunity to provide comments. This deadline can be extended "In exceptional circumstances, for example in complex cases or due to annual leave".[267]

The 2010 Guidelines set out the practical steps for conducting a formal investigation within the Trust.[268] Once the Case Manager, Case Investigator and Designated Board Member have been appointed, the Case Manager must inform the practitioner of the investigation in writing, the identity of the Case Investigator, and the specific allegations raised.[269] The Case Manager must ensure that the practitioner can see all relevant correspondence, witness list and that they have an opportunity to put forward their case.[270] The Case Investigator gathers the information and witness statements and keeps a written record of the investigation, conclusions reached and course of action agreed.

153. At the end of the formal process, the Case Manager is required to make a determination under paragraph 38 of the MHPS Framework. The following specific options are available to them:
    - "no further action is needed;
    - restrictions on practice or exclusion from work should be considered;
    - there is a case of misconduct that should be put to a conduct panel;
    - there are concerns about the practitioner's health that should be considered by the HSS body's occupational health services, and the findings reported to the employer;

265 TRU-292417, Section I, paragraph 37
266 TRU-292417, Section I, paragraph 37
267 TRU-292417, Section I, paragraph 37
268 TRU-83692 to TRU-83700
269 TRU-292416, Section I, paragraph 35
270 TRU-292416, Section I, paragraph 35

- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel."[271]

154. The MHPS Framework provides that:

> "Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned."[272]

The MHPS investigation concerning Mr O'Brien

Commencing the investigation (January – November 2016)

155. In late 2015, having been tasked with reviewing some of the other consultants' patients to assist in managing the Trust's review backlog, Mr Haynes and Mr John O'Donoghue noted that there were often missing or inadequate records on the electronic patient notes system regarding the care, treatment or diagnosis of patients that Mr O'Brien had seen in his clinics.[273] Mr Mackle, AMD, told the Inquiry that it was this which ultimately led to the investigation into Mr O'Brien's practice.[274]

156. These concerns were raised with Mr Mackle and Ms Trouton, Assistant Director, who, in turn, escalated them to Mrs Esther Gishkori, Director of Acute Services,

271 TRU-292417, Section I, paragraph 38
272 TRU-292447, Section VI, paragraph 7
273 TRA-00912, lines 1-13; TRA-09834, lines 3-12; WIT-12007, paragraph 67
274 WIT-11783, paragraph 122

on 21 December 2015.[275] The concerns were further escalated to the Medical Director, Dr Richard Wright, on 11 January 2016.[276]

157. While consideration of using MHPS in respect of Mr O'Brien did not commence until September 2016, and the formal MHPS investigation itself did not commence until December 2016, the seeds of its use were planted in January 2016, when Dr Wright became Medical Director of the Trust. At that point, medical line management (through Mr Mackle) and operational line management (through Ms Trouton) considered that the time was ripe to try to tackle the issues with Mr O'Brien's practice. As Dr Wright explained:

> "They wanted a fresh pair of eyes looking at the situation. It certainly struck me, and we discussed that this matter had been clearly attempted to be managed very informally and with workarounds for a long period of time, and it was time now to deal with this in a more deliberate and intentional manner to bring it to a conclusion."[277]

He continued:

> "I felt that there had been a lack of clarity for Mr. O'Brien as to what was expected of him. I think also the fact that there had been so many workarounds may have led him to believe that some of his behaviour was acceptable. I couldn't see any evidence that that had been laid out clearly for him. I suggested that they met with him and wrote to him, outlining the issues that were concerning them, and indicating that he had to address them within a reasonable time frame. After that, we would see what happened. I don't think I discussed in detail, but there was an implicit assumption that had he required any -- you know, had he come back with a plan, that there would have been support to try and help him achieve it if that was required. I think both Mr. Mackle and Mrs. Trouton suggested that that would be the case. I did think,

275 TRU-277934
276 WIT-17830, paragraph 1.4; TRU-00797, paragraph 13
277 TRA-02527, line 29 to TRA-02528, line 7

and others may judge me wrong, but I thought it was better to ask him for his way of resolving this, because of this history of kickback".[278]

158. The Inquiry considers that the approach taken by Dr Wright was the correct one; until this point no-one had given Mr O'Brien any formal written notice of what was expected of him.

159. This meeting was significant as it was the first time, in a number of years, that concerns about Mr O'Brien had reached the Medical Director. However, Dr Wright characterised the meeting as "informal and not minuted."[279] Similarly, Ms Trouton confirmed that she does not possess any written record of the meeting.[280] The Inquiry was concerned to learn that this meeting, in which issues relating to a doctor's practice were being raised with the Medical Director, was not minuted, although given the culture of medical management at the time it is perhaps not surprising. An 'informal' approach should not be conflated with a casual one. The Medical Director often acts as a sounding board, as was the case here. The least that should have occurred was that he ought to have put something in an email to confirm everyone's understanding of the meeting and he should have given a timescale for feedback following the intervention. It is, plainly, inadequate that no written record of this meeting exists. It is essential that any escalation of concerns, particularly where those concerns have the potential to impact patient safety, or the potential to affect a career, is properly recorded.

160. A letter dated 23 March 2016, addressed from Mr Mackle, AMD, and Ms Trouton, Assistant Director, was given to Mr O'Brien by Mr Mackle and Ms Corrigan on 30 March 2016.[281] This was the first time that concerns about Mr O'Brien's practice had been reduced to formal correspondence by medical management. The letter advised Mr O'Brien that a number of areas of his clinical practice were 'causing governance and patient safety concerns' and specified four issues of concern:

278 TRA-02534, lines 6-24
279 WIT-18433, paragraph 10.1
280 WIT-14811, paragraph 12
281 TRU-251418 to TRU-251419; WIT-39888 to WIT-39889, paragraph 9.17

a. Untriaged outpatient referral letters

There were 253 untriaged letters dating back to December 2014. The lack of triage meant that the Trust did not know whether the patients were red-flag, urgent or routine and this meant patients were therefore allocated on a chronological basis with no regard to urgency.

b. Review backlog

As of 29 February 2016, Mr O'Brien had a review backlog of 679. He had a separate oncology waiting list of 286 patients the longest of whom was due to have been seen in September 2013. Without validation of the backlog, the Trust had no assurance that there were no clinically urgent patients on the list.

c. Patient Centre letters

Consultant colleagues from urology and other specialties were frustrated that there was often no record of consultations and discharges in patient notes. This lack of documentation, combined with no record of clinic outcomes, meant that further investigations and follow-up may not be organised by administrative staff.

d. Storing patient notes at home

The letter noted that this had "been an ongoing issue for years and needs addressed urgently."

The letter requested that Mr O'Brien respond: "with a commitment and immediate plan" to address the issues identified: "as soon as possible."[282]

Whilst this letter marked something of a step change in the Trust's approach to the management of Mr O'Brien, its drafting was not as robust - and thereby not as effective - as it could, and ought to, have been. Other than asking Mr O'Brien to provide an immediate plan, the letter did not set any clear expectations or deadlines. It did not identify the actions Mr O'Brien was expected to take, the timeframe in which he was expected to do so, the consequences of non-compliance, nor the support available to him. Input from HR may have remedied

282 TRU-251419, paragraph 4

this and should have been sought when the letter was being drafted. This letter could have been treated as part of normal medical management and an improvement plan could have been put in place with or without the assistance of NCAS. It appears that this course was not taken, due in particular, to the apparent discomfort of the medical management line.

161. On 30 March 2016, Mr Mackle and Ms Corrigan met with Mr O'Brien to present him with the letter.[283] The reasons for the apparent delay in providing this letter to Mr O'Brien remain unclear. Once again, no note of this meeting is available.[284] The meeting was exceptionally short.[285] Mr O'Brien recalled "We didn't sit down."[286] Ms Corrigan told the Inquiry "I don't even think it lasted 10 minutes."[287] Ms Corrigan explained that it was "not a confrontational meeting in that both Mr Mackle and Mr O'Brien were courteous to each other."[288] She told the Inquiry:

> "I think it was just we gave him the letter, Mr. Mackle just gave the headings, he didn't read the letter in detail. I do recall Mr. O'Brien folded up the letter and asked: "What am I going to do with this?" And I can't recall whether it was myself or Mr. Mackle but I definitely know that we said we had four weeks, we needed a response."[289]

162. Whilst this, broadly, accords with Mr O'Brien's account of the meeting, there was an evidential dispute about whether Mr O'Brien was offered support to address the concerns,[290] or whether the timeframe of four weeks was mentioned at the meeting.[291] Ms Corrigan told the Inquiry that support was offered but not availed of by Mr O'Brien.[292] In contrast, Mr O'Brien told the Inquiry: "I felt that I was being left on my own to try to cope with these concerns."[293] It was Mr O'Brien's

283 TRU-251418 to TRU-251419
284 TRA-03000, lines 21-23
285 TRA-02265, line 16; TRA-03000
286 TRA-04751, line 20
287 TRA-03000, line 24
288 WIT-39888, paragraph 9.17
289 TRA-03000, line 28 to TRA-03001, line 5
290 TRA-04751 to TRA-04752,
291 TRA-04753 to TRA-04755
292 WIT-39889, paragraph 9.19
293 TRA-04755, lines 19-20

evidence that, in response to his enquiry about what to do, Mr Mackle simply shrugged his shoulders.[294] Mr Mackle denied responding in this manner and told the Inquiry:

> "I would have been very careful of my body language for that meeting. I would not have just been shrugging my shoulders if I had been asked."[295]

Irrespective of whether Mr Mackle shrugged his shoulders in this meeting, the meeting was poorly handled. There was a notable lack of strategic planning for this meeting; there was no understanding that there was a need to set out what was expected from Mr O'Brien and the potential consequences of non-compliance with those expectations. No follow-up meeting was planned. As a result, Mr O'Brien did not understand that the letter required a written response. He told the Inquiry:

> "I didn't interpret this at all as me having to reply with a written plan to anyone. … I wasn't asked to reply with a plan. But I responded with all of the actions. … I never even considered that I had to reply with a plan to anyone."[296]

163. Given that it had not been made clear to him that it was necessary to respond in writing by a specific date, no action plan was produced by Mr O'Brien. Nonetheless, the Inquiry is of the view that Mr O'Brien ought to have appreciated that he was expected to provide an action plan setting out how he would do what was required. If he found himself unable to do so he ought to have asked for help. It is concerning to note that, despite the letter of 23 March having expressly acknowledged that the concerns were potentially impacting patient safety, there was no management follow-up to the letter, no ongoing monitoring, nor further engagement with Mr O'Brien until August 2016.[297] This was, at least in part, attributable to significant personnel changes in both the Medical and Service lines of management around this time. Mr Mackle stepped down as AMD in April

294 TRA-04752; TRU-284737
295 TRA-02265, lines 11-13
296 TRA-04754, lines 10-20
297 TRU-251415 to TRU-251416

2016 and was replaced by Dr McAllister.[298] Mr Colin Weir was appointed CD in June 2016.[299] In terms of the Service line of management, Mr Ronan Carroll replaced Ms Trouton as the Assistant Director in April 2016.[300] Therefore, within weeks of the 23 March letter issuing, those responsible for collating and escalating the concerns had left their roles. Ms Corrigan remained in her role and told the Inquiry that:

> "this change in personnel meant that the letter of March 2016 was not followed up as it should have been. On reflection, this was a failing on my part and on the part of others, including those who replaced Mrs Trouton and Mr Mackle."[301]

The Inquiry agrees; it is clear that those newly in post had at least been informed that there were concerns regarding Mr O'Brien.[302]

164. On 09 August 2016, Dr Wright followed the matter up with Ms Corrigan by email.[303] On 17 August, Ms Corrigan provided an update which showed some improvement in respect of outstanding triage but the review backlog remained unchanged.[304] The following day, Dr Wright instructed Mr Gibson, Assistant Director, Medical Director's Office, to "commence a discreet piece of work on issues of concern and actions taken to date."[305] On 22 August, Mr Gibson emailed Mr Mackle, Dr McAllister, Mr Carroll and Ms Trouton asking each of them to confirm whether they had received any plans or proposals from Mr O'Brien to address the concerns outlined in the letter of 23 March.[306] However, no one had received any such plan.[307]

298 WIT-14849, paragraph 1.2
299 WIT-19902
300 WIT-13086
301 WIT-39890, paragraph 9.22
302 TRU-274671; TRU-274695; WIT-14875
303 TRU-274723
304 TRU-274723
305 TRU-274722
306 TRU-251417
307 TRU-251416; TRU-251420; TRU-277980; WIT-11807

165. Dr McAllister and Mr Weir were also engaged in discussions about the matter at this time and when he received Mr Gibson's email, Dr McAllister forwarded it Mr Weir, stating:

> "It appears that the boat is missed. … Please hold off on attempting to address this issue until the dust settles on the process below."[308]

In a further email, Dr McAllister described this development as:

> "V[sic] disappointing. This is not the direction of travel I wanted for many reasons."[309]

Dr McAllister explained to the Inquiry:

> "I think we hadn't been given a chance to come up with a strategy for effectively dealing with Mr. O'Brien's issues on an ongoing basis."[310]

However, he conceded that he did not approach Dr Wright to seek an opportunity to deal with the issues in this manner.[311] Mr Weir explained that it would have been 'wrong' for him and Dr McAllister to have continued their own process once the Medical Director had become involved.[312]

166. This is illustrative of the fact that medical and operational management were not working as one to resolve matters and patient safety was not being given the primacy that it ought. More is said about this in the Medical Management and Leadership and Governance chapters.

167. Mr Gibson produced a 'screening report' on the concerns regarding Mr O'Brien, which was shared with the Medical Director on 05 September 2016.[313] The report

308 WIT-14885
309 WIT-14885
310 TRA-02782, lines 23-25
311 TRA-02782, line 26 to TRA-02783, line 5
312 TRA-02666, lines 1-2
313 TRU-251422 to TRU-251424

addressed the four issues covered in the March 2016 letter which were all still present and unresolved. The report concluded that:

> "previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm."[314]

168. Mr Gibson, as an Assistant Director in the Medical Director's Office, was not the appropriate individual to prepare such a report and offer assurance to the Medical Director. To be clear, the Inquiry makes no criticism of Mr Gibson for this; he should not have been asked to carry out this role. He was not a medically qualified Clinical Manager of Mr O'Brien's. Both the MHPS Framework and the 2010 Guidelines envisage any preliminary enquiries or screening exercise should be conducted by a Clinical Manager.[315] Mr Gibson readily acknowledged this himself, explaining:

> "I undertook the screening of concern as the Medical Director directly asked me to, and the concerns under consideration with [sic] administrative and statistical in nature, rather than any concerns requiring clinical consideration."[316]

Dr Wright explained that he had asked Mr Gibson to undertake this role as he: "wanted this done quickly" and "wanted to get on top of this as a matter of some urgency."[317] It was his view that, if he had asked one of the CDs:

> "this would have been on top of their already incredibly busy workload, and I don't think it would have been done just as quickly."[318]

314 TRU-251424, Conclusion
315 TRU-292413, paragraph 15; TRU-83688, Paragraph 2.4
316 WIT-33938, paragraph 29.2
317 TRA-02555, lines 15-19
318 TRA-02555, lines 20-23

169. The Inquiry considers that asking Mr Gibson to carry out this task was a fundamental mistake on the part of Dr Wright. The MHPS is fraught with difficulty and failure to follow process is the most common grievance raised. Dr Wright ought to have ensured that the exercise was carried out by the CD, who could have been assisted by Mr Gibson.

170. The significance of this exercise having been conducted by a non-medically qualified individual was succinctly captured in the evidence of Dr Colin Fitzpatrick, NCAS Senior Adviser, who explained that:

> "The categorisation of the initial concern can make a significant difference to how a case progresses, with the distinction between capacity (with options for assessment and remediation) and conduct (which can lead to a disciplinary). If Simon Gibson did not know about any clinical capability concerns in September 2016, that avenue under the MHPS Framework … effectively disappeared."[319]

Mr Gibson confirmed that he was not tasked with expanding the investigation beyond the four concerns reflected in his final report.[320] As a result, from this point forward, the die was effectively cast; the issues identified in the March 2016 letter and Mr Gibson's report became the focus of the MHPS investigation. For this, the Medical Director must bear ultimate responsibility.

171. Around this time, after the completion of Mr Gibson's report, Mr Haynes contacted Dr Wright to alert him to patient safety issues. Dr Wright explained that, following that telephone call, he arranged an Oversight Committee meeting to discuss the issues raised and directed Mr Gibson to contact NCAS in advance of the meeting to discuss possible approaches.[321] The Inquiry considered the reasons Dr Wright gave for asking Mr Gibson to contact NCAS which essentially

319 WIT-53791, paragraph 13
320 TRA-02881, lines 25-28
321 WIT-17882, paragraph 55.3

amounted to the fact that it was quicker, clinicians were under huge pressure and it would not have made a material difference.[322] This was a mistake on Dr Wright's part, it represented a missed opportunity to ensure all clinical matters were considered in detail at this time. The Inquiry considers that Dr Wright ought to have contacted NCAS himself. We also believe that NCAS ought to have asked to speak to a medical manager, whether Dr Wright or an AMD.[323] The Inquiry raised this with PPA who do not accept this, insisting that the responsibility for decision-making and escalation remains with the Trust and it is not the role of NCAS to substitute or duplicate those internal processes. The Inquiry acknowledges this as a general rule, however Dr Fitzpatrick recognised this was an extremely important call usually made by a senior medical manager. In those circumstances NCAS should have questioned why the call was not coming from a medical manager.

172. On 13 September 2016, Dr Fitzpatrick wrote to Mr Gibson to follow-up on a telephone call on 07 September.[324] The letter noted that:

> "To date you [the Trust] are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology."[325]

NCAS suggested that disciplinary action could be initiated regarding the storage of notes, that poor note taking should be the subject of an audit and that:

> "problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward."[326]

What Dr Fitzpatrick was suggesting the Trust do, ought to have been done long before this stage and would have been appropriate. The Trust did not realise that

322 TRA-02555 to TRA-02556
323 TRA-03274 to TRA-03275 and TRA-04283, oral evidence of Dr Wright and Dr Fitzpatrick (NCAS) respectively where they confirm that the phone call to NCAS and the discussion that is part of that call is extremely important and would generally be carried out by an MD or at least an AMD.
324 TRU-266193 to TRU-266194
325 TRU-266193
326 TRU-266194

the scale of the administrative issues was a serious alarm bell that there was a risk to patient safety, and it did not communicate this to NCAS. This was a failing.

173. On 13 September 2016 an Oversight Committee was convened. Despite Trust guidelines stating that the Chief Executive of the Trust, then Mr Francis Rice, is responsible for appointing an oversight group,[327] this Oversight Committee was not so appointed. At the meeting it is recorded that Dr Wright (Medical Director), Mrs Gishkori (Director of Acute Services), Ms Toal (HR Director), Mr Gibson and Mr Malcolm Clegg (Medical Workforce Manager) were in attendance.[328] With the exception of Dr Wright, no one meeting the description of Mr O'Brien's 'clinical manager' was in attendance. The minutes of the meeting are scant, containing no reference to any discussion with NCAS and simply recording agreed actions; namely, that Mr Gibson was to draft a letter to be presented to Mr O'Brien by Mr Weir and Mr Carroll the following week. The purpose of the letter was to inform Mr O'Brien that an informal investigation under MHPS was being initiated and that he had four weeks to address the identified areas of concern.[329] In the absence of the Clinical Manager, the Oversight Committee could not, properly, have been performing its role of 'quality assuring' the decision and recommendations following informal assessment by the Clinical Manager and HR Case Manager, as prescribed by the 2010 Guidelines.[330] As Ms Toal reflected, this was:

> "problematic, and meant that the Oversight Group was driving the decision making in relation to the early actions in September 2016, as opposed to the Clinical Manager"

resulting, in turn, in an approach which was contrary to the MHPS Framework.[331]

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327 TRU-83688 to TRU-83689, "Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance 23 September 2010", paragraph 2.5
328 TRU-00025
329 TRU-00026
330 TRU-83701, Appendix 6
331 WIT-41138 paragraph 26(iii); TRU-292413 Section 1, paragraph 15

174. Later that same day, Mr Gibson circulated a draft of the agreed correspondence to the members of the Oversight Committee.[332] In contrast to the previous letter of 23 March, this letter set clear targets for Mr O'Brien to address the identified issues: triage of outpatient referral letters was to be completed within the Trust standard of 72 hours; the outpatient review backlog was to be reduced by a minimum of 70 patients per month; notes were not to be stored at home, without exception; and notes regarding outpatient consultations or inpatient discharges were to be made contemporaneously.[333] However, this letter was not issued to Mr O'Brien and the agreed actions of the Oversight Committee never took place.

175. On 14 September 2016, Mrs Gishkori discussed the matter with Dr McAllister.[334] In a follow-up email to Dr McAllister, Mrs Gishkori wrote:

> "I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
> We owe this to a well respected and competent colleague.
> I can confirm that you will have communication in relation to this before the end of the week."[335]

176. In a further email to Dr Wright and Ms Toal, on 15 September 2016, Mrs Gishkori indicated that the clinical managers had:

> "plenty of ideas to try out and since they are both relatively new into post, I would like to try their strategy first" [336]

and sought three months to resolve the issues raised in relation to Mr O'Brien's performance. She told us in evidence that she feared that if an informal MHPS approach were taken Mr O'Brien would walk away, leaving an already stretched service in more difficulty.[337]

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332 TRU-251429 to TRU-251431
333 TRU-251430 to TRU-251431
334 TRA-06789; TRU-263678; TRU-263681
335 TRU-257636
336 TRU-263678
337 TRA-03136

177. In a reply later that day, Dr Wright indicated that he would require sight of the plans in place to deal with the issues and to understand how progress would be monitored over the three month period.[338] Ms Toal was also unhappy with the approach.[339] Whilst Mr Weir, Dr McAllister and Mr Carroll had proposed an action by the following week,[340] this does not appear to have been implemented, nor shared with Dr Wright.[341] Shortly thereafter, Dr McAllister ceased to be AMD; he was not replaced until September 2017.

178. The failure to issue the draft letter of 13 September was a missed opportunity to manage Mr O'Brien and communicate the Trust's clear expectations to him. This was not helped by Mrs Gishkori's intervention, which may, as she said, have been because of a need to ensure that the urology service could be sustained, but may also have been tainted by a fear of upsetting Mr O'Brien. Moreover, it is unclear how the Medical Director could have assured himself that patient safety was being protected in the absence of any action plan, or any further update, having been provided to him.

179. A further meeting of the Oversight Committee took place on 12 October 2016.[342] It was noted that Mr O'Brien was to be off work in November for health reasons. Mrs Gishkori reported that Mr O'Brien had not been told of the concerns raised but indicated that:

> "a plan was in place to deal with the range of backlogs with Mr O'Briens [sic] practice during his absence."[343]

An assurance was offered by Mrs Gishkori that, upon his return, the administrative practices would formally be discussed with Mr O'Brien.

338 TRU-263678
339 TRA-03354 to TRA-03359; TRU-263681
340 TRU-257640; TRU-281277
341 WIT-33924, paragraph 14.8
342 TRU-00031
343 TRU-00031

180. At no time during this period was Mr O'Brien informed about any meetings regarding his practice. While this may have been so as not to upset him due to his upcoming sick leave, it was poor practice. Mr O'Brien ought to have been made aware of the fact that discussions were taking place at a senior level as soon as they commenced.

181. Prior to this sick leave Mr O'Brien offered to attend to administrative duties at home while he was on sick leave. This was condoned and approved by Ms Corrigan as HOS[344] but was not discussed with any clinical manager. The Inquiry considers that this was poor practice and was a failure of extant systems of management.

182. In or about this time, an SAI report in respect of Patient 10 was nearing completion. On 09 November 2016, Dr Boyce (Director of Pharmacy) emailed Mrs Gishkori following a meeting of governance leads at which there was concern about the implications of the SAI as the cause seemed to be "directly attributable to one of the consultants (AOB)?"[345] By 30 November 2016, Mrs Gishkori had briefed Dr Wright about the SAI, and later proposed that Mr O'Brien's return to work interview might represent "a good time to set out the ground rules from the start."[346]

183. On 15 December 2016, the SAI Review Team wrote to Dr Boyce setting out:

> "issues/themes causing concern for the panel which have been exposed during the SAI investigation."[347]

On 20 December 2016, Mr Carroll, Dr Boyce and Mrs Gishkori subsequently discussed the letter in which three issues were identified:

344 Email exchange quoted verbatim at AOB-15014, emails at AOB-15140 and AOB-15141
345 TRU-255890
346 TRU-251826 to TRU-251827
347 TRU-170303 to TRU-170305

i. In May 2014, an informal process was implemented to monitor/manage urology letters which had not been returned with management advice (not triaged). The Review Team were "anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved."[348]

ii. During a manual look-back exercise a patient's chart could not be found and it was established that patient notes were not transported via Trust vehicles to Mr O'Brien's six outlying clinics (including South West Acute Hospital) and

iii. The Review Team had "grave concerns that there are other Urology patient letters not being dictated in a timely manner." [349]

184. The Booking and Contact Centre provided an update on 20 December 2016, indicating there were over 60 clinics, dating back to 24 November 2014, in respect of which Mr O'Brien had not completed dictation.[350] Mrs Gishkori shared this information with Dr Wright who described it as "worrying developments". In response Dr Wright scheduled a meeting of the Oversight Committee for 22 December, advising members "I don't think we can wait for the formal completion of SAI [sic]."[351]

185. The Oversight Committee met on 22 December 2016.[352] Prior to the meeting, a spreadsheet of outstanding triage, the final draft of the SAI report in respect of Patient 10 and a summary of the letter of 15 December 2016 were circulated to attendees.[353] Once again, neither of Mr O'Brien's clinical managers were present.[354] Three issues were discussed at the meeting:

a. The SAI in respect of Patient 10, which highlighted delays in Mr O'Brien's triaging of referrals. Mr Carroll reported that, between July 2015 and October 2016, there were 318 referrals not triaged.

348 TRU-170304
349 TRU-170304
350 TRU-255967 to TRU-255970
351 WIT-41585 to WIT-41586
352 TRU-00033 to TRU-00034
353 TRU-01393 to TRU-01417
354 WIT-41071, paragraph 15(iv)

b. Concern that notes were being stored in Mr O'Brien's home, with the attendant concern that the clinical management plans for these patients was unclear and may, therefore, be delayed.
c. A backlog of over 60 undictated clinics, dating back over 18 months and affecting approximately 600 patients, meaning the Trust was unclear about what the clinical management plan was for these patients.[355]

186. In addition to agreeing that a written action plan with a clear timeline would be submitted to the Oversight Committee on 10 January 2017, the Committee agreed that Mr O'Brien's administrative practices had "led to the strong possibility that patients may have come to harm" and that, should he return to work:

> "the potential that his continuing administrative practices could continue to harm patients would still exist."[356]

On this basis, the Oversight Committee:

> "agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach."[357]

There was no mention of the previous NCAS advice which had not been actioned or followed up as it should have been. The Inquiry notes that the September NCAS advice should have been followed up in October 2016 and that it was not shared with the Oversight Committee or with Mr O'Brien. It was agreed that Dr Wright would phone NCAS to confirm the approach and aim to meet Mr O'Brien on 30 December 2016 to inform him of the decision. Mr Weir was to be the Case Investigator and Dr Ahmed Khan the Case Manager.[358] The Inquiry notes that NCAS advice should have been sought prior to the decision to exclude Mr O'Brien but accepts that Dr Wright was aware of this and understood that if

355 TRU-00033 to TRU-00034
356 TRU-00033 to TRU-00034
357 TRU-00033 to TRU-00034
358 TRU-00033 to TRU-00034

NCAS had not agreed with the recommendation to exclude, then he would have reconvened the Oversight Committee.[359]

187. The Trust's handling of the concerns relating to Mr O'Brien across this period was exceptionally poor. Despite a number of attempts to grasp the issues, there is a catalogue of missed opportunities, beginning with the letter of 23 March 2016. The absence of follow-up, consistent monitoring, adequate written records and strategic planning meant that early efforts to engage with Mr O'Brien in Spring 2016 were wholly ineffective. The Trust's management cadre was beset with a high level of turnover throughout this period. Aside from contributing to instability, this hindered continuity of the minimal oversight that was being exercised in respect of the management of these concerns. Significantly, Trust management did not engage directly with Mr O'Brien about the concerns which had been identified in a sufficiently clear manner between January and November 2016.

188. Throughout this period, the Oversight Committee appears to have been confused in terms of both its purpose and operation. Ultimately, this hindered the efficiency of the process and gave a false sense of leadership at a time when, in reality, there was little.

189. It is a matter of greater concern that, at no time throughout this period, did anyone seek to ascertain the extent to which patients were, in fact, coming to harm. In the absence of any proper follow-up, monitoring, or action plan, the Trust simply could not assure itself that patients were not coming to harm.

190. Whilst the issues had been known by Dr Wright since around January 2016, it is clear that the letter from the SAI Review Team to Dr Boyce in December 2016 was the catalyst for the MHPS investigation. Had this not arisen, it is not clear that a formal MHPS investigation would have been initiated in December 2016, if at all. It appears that Mr O'Brien and others were not aware of this SAI

359 TRA-02607

investigation which was lengthy and only concluded after many months.[360] The Review Panel considering Mr O'Brien's grievance reached the same conclusion and suggested that, had it not been for the SAI in respect of Patient 10:

> "The plans to work around Mr O'Brien are likely to have continued as they had for years previously."[361]

This Inquiry reaches the same conclusion.

191. The decision to commence a formal investigation meant that informal resolution of the issues in a collaborative manner was no longer a possibility. Moreover, given that the Trust's efforts to resolve the matter informally prior to this point were ineffective, the Inquiry is satisfied that the decision to move to a formal MHPS process at this point was, nevertheless, the correct one.

'Scoping' and exclusion (23 December 2016 – 26 January 2017)

192. On 23 December 2016, Mr Haynes (Consultant Urologist) emailed Mr Carroll to escalate an issue with regard to Mr O'Brien's management of private patients which he considered "should also be looked into."[362] Mr Haynes highlighted an example of a patient who had been seen privately by Mr O'Brien on 05 September 2016 and placed on his NHS theatre list on 21 September (16 days later). Mr Haynes noted that Mr O'Brien's waiting list had many other patients awaiting the same procedure who had been waiting "significant lengths of time" and indicated his belief that:

> "if his [Mr O'Brien's] theatre lists were scrutinised over the past year a significant number of similar patient admissions would be identified. This practice has a negative impact on our overall waiting times and is in my view totally unacceptable."[363]

360 See Serious Incident section of the Governance chapter
361 TRU-158812, paragraph 4.10, contained in the report of the Stage One Grievance panel at TRU-158807 to TRU-158818
362 TRU-256014
363 TRU-256014

This was not the first time Mr Haynes had escalated this issue. As set out earlier in this chapter, on two occasions in 2015 he had raised this concern with Ms Corrigan (HOS) and Mr Young (CL).[364]

193. On 28 December 2016, Mr Carroll informed Dr Boyce, Dr Wright and Mr Gibson of the private patient issue. Mr Carroll asked for a report on Mr O'Brien's TURP procedures for the year 2016.[365]

194. The same day, advice was sought from NCAS. NCAS agreed with the decision to exclude Mr O'Brien but suggested that the exclusion should be an immediate exclusion for a period of four weeks rather than a formal exclusion. This would allow some time to gather information and assure patient safety. A four week period would also allow options other than exclusion to be considered during the course of the information gathering. They also advised that on the basis of the information shared, a formal investigation was likely to be required[366] and noted that any formal investigation:

> "should not be an unfocused trawl of Dr 18665's [Mr O'Brien's] work" and that "if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/ look back … further preliminary information (such as from the SAI and taking account of Dr 18665's comments) may be helpful in deciding the scope of the investigation and therefore the ToR."[367]

This was to prove an important statement as it may have caused too little curiosity regarding any wider clinical issues. All the issues relating to Mr O'Brien that became part of the MHPS investigation had already been raised prior to this point, including the issue relating to private patients.

364 WIT-54106 to WIT-54107
365 TRU-256014
366 TRU-159142 to TRU-159144
367 TRU-159142 to TRU-159144

195. Notably, the NCAS advisor who spoke to Dr Wright in December was not the same NCAS advisor who had been involved in September 2016 and it seems likely, based on the evidence of Dr Grainne Lynn (an advisor with the Practitioner Performance Advice (PPA) service (formerly NCAS), before the Inquiry, that the information from the September contact was not shared due to a failure of NCAS's system of linking case numbers.[368] The two separate calls were subsequently linked. Neither call was effectively followed up by the Trust.[369]

196. A meeting with Mr O'Brien was set for 30 December 2016. An agenda prepared in advance of the meeting had three items:

1. "To discuss an investigation into alleged irregularities of patient note keeping and review triage, under the framework of maintaining higher professional standards.
2. To discuss the date of your planned return to work.
3. To clarify Trust expectations regarding the return of patient notes that have been tracked out to you."[370]

197. Ms Lynne Hainey (Acting HR Manager), who was due to attend the meeting, emailed Ms Siobhan Hynds the day before, observing that the agenda:

> "sounds misleading ie to discuss the date of your planned return to work, whenever a decision has been made to exclude."[371]

198. On 30 December 2016, Dr Wright and Ms Hainey met with Mr O'Brien. His wife accompanied him. As Mrs O'Brien made an audio recording of this meeting, a transcript of the meeting was available to the Inquiry.[372] The recording was made without the knowledge of Dr Wright or Ms Hainey and was therefore not

368 TRA-04400 to TRA-04404
369 NCAS advisers – Dr Colin Fitzpatrick and then Dr Grainne Lynn
370 TRU-00074
371 TRU-00073
372 AOB-56001 to AOB-56017

authorised by them. This was the first meeting of any kind with Mr O'Brien regarding the concerns since March 2016. It was at this meeting that Mr O'Brien was informed of his immediate exclusion and the investigation under MHPS. During the meeting, Mr O'Brien was informed of the concerns with regard to his triage, storage of notes and undictated outcomes.[373] It was made clear to Mr O'Brien that he was to return all patient notes from his home by 11am on 03 January 2017.[374] Despite the Medical Director having been informed of the private patients issue on 28 December, that issue was not discussed at this meeting. Ms Hainey suggested that this was because:

> "it was not agreed upon by the oversight committee and we agreed that any other concerns can be added as required."[375]

199. The Inquiry considers that this was not a good enough reason. It is indicative of a sense of panic in decision-making and a lack of forethought. It was an issue that required consideration and ought to have been discussed by the oversight committee. As it was, the committee did not follow through on its purpose and the Medical Director, HR Director and the Chief Executive ought to have convened a meeting to bring order to the proceedings.

200. In the course of the meeting, Mr O'Brien asked whether he could continue to work with private patients. The transcript of the meeting suggests there may have been some confusion on the part of senior management as to whether he could be permitted to continue his professional practice during the exclusion. Dr Wright advised Mr O'Brien:

> "The normal expectation would be that you wouldn't be undertaking private work but that's not something I can be (inaudible). At the end of the day, I think you need to read what's in there and it is a decision you can make yourself but if the private patients are linked or are trust patients it could cause some

373 AOB-56002 to AOB-56003
374 AOB-56008
375 TRU-00108

problems. So I would normally recommend that you don't. But clearly if there are within those bounds, people who are urgent clinically. … It is clear if you don't but (inaudible). If you could avoid that for a period of time of time [sic] it would be better. … Another way of doing it would be to ask a colleague to review him or a (inaudible). I think it is -- read the guidance and you need to make a call on that one. But what I would say is that obviously patients at risk first and foremost but I would be discouraging it in general obviously."[376]

Dr Wright's response to Mr O'Brien's query was far from clear, however the Inquiry has not seen any evidence to suggest that Mr O'Brien did continue to practice privately during this period.

201. The MHPS Framework states that:

"Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer."[377]

The apparent uncertainty on the part of senior management is likely a reflection of the fact that Mr O'Brien operated his private practice from his home, as opposed to from a private hospital, and therefore did not have a private 'employer'. Dr Wright does not appear to have taken the trouble to ascertain precisely how Mr O'Brien's private practice was conducted or even to check what evidence had been presented at appraisal regarding same. More is said about this issue in the Clinical Aspects chapter.

202. This also highlights a further difficulty with the MHPS process in that it does not cover private practice.

203. On 02 January 2017, Mr O'Brien returned 307 charts from his home, including 94 Trust patients that Mr O'Brien had seen privately and recorded his private

376 AOB-56016 to AOB-56017
377 TRU-292422, Section II paragraph 22

notes in their health service charts. A further 88 sets of notes were retrieved from his office. A report from the Patient Administration System (PAS) identified that 27 sets of notes were not available.[378] On 09 January 2017, Mr O'Brien provided Ms Corrigan with copies of 668 outcome sheets for patients who had been seen in clinic but in respect of a large number of whom he had not dictated. Mr O'Brien contends there were 189 patients for whom he had not dictated. Ms Corrigan told the Inquiry that she still had to check all 668 sets of notes in order to ascertain whether or not the dictation was in fact complete or missing.[379] That same day, having been made aware of the presence of records in his filing cabinet by Mr O'Brien, Ms Corrigan discovered 783 un-triaged letters dating back to June 2015.[380]

204. Mr O'Brien's consultant colleagues were then tasked with conducting a clinical note review of all charts and referrals letters returned by Mr O'Brien to assess whether patients had a clinical management plan or required a clinical review with a Urologist.[381] The consultant urology team, Mr Young, Mr Glackin, Mr Haynes and Mr O'Donoghue, worked throughout January to triage these letters, and planned completing this task by the end of the month.[382] With regards to the undictated clinics, Ms Corrigan carried out an administrative review of all affected patients to ensure they were on the waiting list and had tests ordered before arranging for the consultants to review the charts to ensure no patients required appointments.[383] This exercise was not completed until June 2017 due to the number of patients; the need to check the Northern Ireland Electronic Care Record (NIECR) and PAS; and the input from the consultants.[384]

205. It was not until 06 January 2017 that Mr O'Brien received written confirmation of his immediate exclusion.[385] Aside from that correspondence, he did not have any

378 TRU-257707
379 TRA-07352, lines 6-16
380 WIT-14376; WIT-14388
381 TRU-00089; TRU-00101
382 TRU-00037
383 WIT-26150, paragraph c
384 WIT-39909, paragraph 16.12(c); TRA-03021, lines 2-13
385 TRU-263719 to TRU-263722 (letter erroneously dated 2016)

further communication with the Trust until 16 January 2017, when he telephoned Mr Weir, the Case Investigator, to seek an update.[386] The following day, Mr O'Brien wrote to Dr Wright advising that he was "concerned with regard to the slow pace of proceedings" and expressing his concern that no meeting had been arranged to permit him to state his case.[387] It should not have fallen to Mr O'Brien to seek updates in this manner.

206. Mr Weir and Ms Hynds (Head of Employee Relations) met with Mr O'Brien on 24 January 2017.[388] The private patient issue was raised with Mr O'Brien for the first time at this meeting.[389] Mr Weir informed Mr O'Brien that, given the scale of the scoping exercise which was not, by that stage, complete, the investigation process would not conclude within a four-week timeframe. The meeting note records that:

> "Assurances were provided that the investigation process will be as expeditious as possible."[390]

207. On 26 January 2017, a case conference took place.[391] The position, as reported at the meeting, was as follows:

(1) Triage: Of the 783 referral letters from Mr O'Brien's office, 90 patients had already been seen (due to the normal operation of the waiting list and, therefore, had never been triaged). The consultant urologists had returned 330 letters triaged, of which: nine patients were upgraded to red flag, seven patients had seen a consultant and met the Red Flag Criteria but were never triaged, and 28 patients were upgraded from routine to urgent. The remaining 363 letters were to be completed by the end of January.[392]

386 TRU-267280 to TRU-267281
387 TRU-267302 to TRU-267304
388 AOB-60379 to AOB-60383
389 AOB-60379 to AOB-60383
390 AOB-60381, paragraph 6
391 TRU-00037 to TRU-00040
392 TRU-267424

(2) Missing Notes: Further investigation found 13 sets of patient notes tracked out to Mr O'Brien were still missing.[393]

(3) Undictated Clinics: This had not been considered in detail due to the consultant urologists' attention on triage. However, a review of one clinic found two patients with nothing written in the notes but with an outcome, four oncology patients overdue review appoints and four patients who should have had diagnostics or procedures.[394]

(4) Private Patients: Mr O'Brien's elective admissions for 2016 had been obtained but not reviewed in detail. A "snapshot" of TURP (transurethral resection of the prostate) patients highlighted that, the typical wait at that point was 1050 days, eight TURP patients of Mr O'Brien were found to have waited between nine and 303 days from being added to the waiting list to their operation date.[395]

208. A preliminary report by Mr Weir, as Case Investigator, was considered at the meeting, together with Mr O'Brien's representations at the meeting of 24 January.[396] Dr Khan told the Inquiry of his disappointment that the report had only been sent to him shortly before the meeting was due to commence, and whilst he was performing clinical duties, so that he could not study its contents in advance of the meeting.[397] This highlights the difficulty with asking busy clinicians to carry out the work.

209. The minutes of the meeting record that:

> "In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon."[398]

Whilst Mr Weir was clear that he had met with Mr O'Brien on 24 January as the Case Investigator, he acknowledged that he:

393 TRU-267425
394 TRU-267425
395 TRU-267426
396 TRU-00037 to TRU-00040
397 TRA-03893 to TRA-03894
398 TRU-00038, paragraph 5

> "proposed and advocated for a return to work with either restricted duties or robust monitoring of Mr. O'Brien's practice"[399]

during the case conference based on his:

> "personal knowledge of working with Mr. O'Brien, seeing him operate and operate with him in the elective and emergency situation and having his assistance for me at short notice".[400]

It ought to have been no part of Mr Weir's role as Case Investigator to speak in support of Mr O'Brien at that point in the process, if at all. He should simply, and impartially, have presented the findings of his preliminary investigation which were relevant to the key decisions which needed to be taken. No one present at the meeting challenged Mr Weir's advocacy although Dr Khan conceded that it 'would have been better' if Mr Weir had not addressed matters in this way.[401] In the Inquiry's view, it was inappropriate for Mr Weir to advocate for Mr O'Brien in his capacity as Case Investigator. This should have been recognised at the time and challenged by those present at the meeting.

210. The minutes of the Case Conference record that:

> "As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, …
> This decision was agreed by the members of the Case Conference, and therefore a formal investigation would now commence, with formal Terms of Reference".[402]

399 WIT-19908, paragraph 32
400 WIT-19908, paragraph 32
401 TRA-03900, lines 3-8
402 TRU-00039, paragraphs 2-3

It was further decided that Mr O'Brien's exclusion would be lifted the following day and that Mr O'Brien would return to work subject to monitoring which was to be put in place by Mrs Gishkori and Mr Carroll, with any further concerns to be brought back before the Oversight Committee.[403] It was also agreed that there should be an urgent review of Mr O'Brien's job plan.[404]

211. Dr Khan told the Inquiry that he took the decision that there was a case to answer after:

> "considering all evidence presented & with the advice from the oversight committee"[405]

> "it wasn't very clear to me at the beginning what my role as Case Manager would involve. The Oversight Committee was comprised of The Medical Director, Director of HR, and Director of Acute Services. This committee was already involved and had made some decisions for this case, so this blurred roles and responsibilities for me."[406]

212. The MHPS Framework refers to the possibility of adopting an informal approach.[407] Dr Khan was asked by Counsel to the Inquiry to explain whether, having reached the view that there was a case to answer, he considered that there were other procedural options available to him as Case Manager. In response, he indicated that, in his view, a formal investigation was necessary but did not suggest that he had any awareness that there were other possible approaches to the problem, still less that he had considered them.[408]

213. It is not entirely clear which stage of the MHPS Framework/2010 Guidelines the period from 23 December 2016 to 26 January 2017 falls into. The Oversight Committee had already decided (on 22 December 2016) to conduct a formal

403 TRU-00039
404 TRU-00040
405 WIT-31979, paragraph d; WIT-31981, paragraph 10.6
406 WIT-31979, paragraph f
407 TRU-292413, Section I, paragraphs 15-17
408 TRA-03900 to TRA-03902

investigation under the MHPS guidelines and Mr Weir, Dr Khan and Mr John Wilkinson had been appointed as Case Investigator, Case Manager and Designated Board Manager, respectively.[409] Nevertheless, on 30 December 2016, Dr Wright was indicating that the Trust was engaging in a:

> "four week period to scope out the scale of potential problems in relation to Mr O'Briens [sic] administrative practices, which may have led to patients coming to harm, and form the Terms of Reference of a formal investigation."[410]

Indeed, by the time of the meeting with Mr O'Brien on 24 January 2017, this scoping exercise remained ongoing. The characterisation of this phase of the formal investigation as a 'scoping exercise' suggests that, despite having taken the decision to move to a formal investigation, the Trust continued to engage in an exercise more akin to that envisaged in the preliminary enquiries or 'screening process' phase. This work should have been done at a much earlier stage and, certainly, before the decision to commence a formal investigation was taken.

214. We are satisfied that the decision to exclude Mr O'Brien at this time was the correct one, but it was badly handled by the Trust. Throughout this period, the quality of the Trust's communication with Mr O'Brien was extremely poor. The first occasion on which Mr O'Brien was made aware that any of these steps had been taken was when he was invited to the meeting with Dr Wright on 30 December, just a few days prior to his return to work. It seems unkind, if not highly unusual, that a doctor who was on sick leave should have been summoned to the Medical Director's Office just before New Year to deliver the news that he had been excluded in circumstances where all of the issues were known about and had been allowed to continue for such a long time without any reasonable preliminary steps to set out expectations and consequences. It is imperative that, where an investigation into a doctor's practice is commenced, the Trust communicates with openness and clarity to ensure that the doctor is fully updated about the investigation and is able to effectively contribute to it.

409 TRU-00034
410 TRU-00088, contained within email and letter to Michael McBride at TRU-00087 to TRU-00088

215. The opportunity to receive further guidance from NCAS was not explored following this process, although there was apparently an attempt by Dr Khan to do this in January 2017.[411] NCAS themselves asked for updates by email on three occasions in the spring of 2017 and received no reply. They eventually closed the case.[412] The Inquiry considers this to have been a missed opportunity to get support for the Trust and Mr O'Brien, who was unaware of NCAS involvement, during the difficult and lengthy investigation.

216. Mr O'Brien was monitored on his return to work and his job plan was supposed to have been looked at. This was not sufficient.[413] The Inquiry considers that Mr O'Brien's return to work should have been accompanied by a supportive action plan in order to ensure that patients were fully protected and Mr O'Brien assisted to make the changes required. This would have included an urgent job plan review and a support plan agreed with clinical managers and with NCAS, so that the work was demonstrably manageable. It should not have required, for example, work to be done during annual leave.[414]

The investigation (January 2017 – June 2018)

217. Draft ToR for the investigation had initially been prepared by Mr Gibson on 28 December 2016.[415] These Draft ToR were subsequently amended on 29 December 2016 and 19 January 2017.[416] At the time of sharing the further amended ToR with Ms Hynds, Ms Toal, Dr Wright and Mrs Gishkori on 19 January 2017, Mr Gibson explained that he had sought to ensure they were:

> "as specific, focused and quantitative as possible, by adding in the information presented by Ronan at the 10th January meeting"

411 TRU-285015
412 WIT-53451, paragraph 16
413 See paragraph 280 below
414 AOB-01698: Mr O'Brien complying with action plan by doing administrative duties on annual leave days
415 TRU-251445; TRU-251449 to TRU-251450
416 TRU-267208 to TRU-267209; TRU-251490 to TRU-251493

and advised that:

> "the learning from another case in relation to non-chronological scheduling of patients is that this element in particular is better if very specific."[417]

218. The settled ToR set out the following matters for investigation:

1 (a)	To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.
(b)	To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay to treatment as a result.
(c)	To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.
(d)	To determine if any un-triaged patient referrals or delayed triages in 2015 or 2016 resulted in patients being harmed as a result.
2 (a)	To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.
(b)	To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within urology or within other clinical specialties.
(c)	To determine if any patient notes tracked to Mr O'Brien are missing.
3 (a)	To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.
(b)	To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

417 TRU-251490

(c)	To determine if there have been delays in clinical management plans for these patients as a result.
4.	To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.
5.	To determine if any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

However, the ToR expressly indicated that this list did not preclude investigation of any further issue of concern which may arise during the course of the investigation.[418]

219. On 21 February 2017, having taken legal advice, Dr Wright considered that it was necessary to appoint a different Case Investigator due to a "potential conflict of interest" between Mr Weir's role as Case Investigator and his role as Mr O'Brien's CD at the relevant time.[419] Dr Wright told the Inquiry:

> "I wouldn't have said it was a direct conflict but it was apparent that it was becoming a problem for him and may have become a bigger problem down the line as the investigation went on."[420]

Dr Neta Chada agreed to take over the role. Given that the investigation had not been significantly advanced since January 2017 in any event, the replacement of the Case Investigator did not cause any undue delay in the process. However, the potential for, at the least, a perceived conflict of interest, was obvious from the outset and, as such, ought to have been considered at the time of his appointment.

418 TRU-267981 to TRU-267984
419 TRA-03244, lines 4-16; TRA-03245, line 27 to TRA-03246, line 1; TRU-267745
420 TRA-03245, line 27 to TRA-03246, line 1

220. The fifth ToR was developed by Dr Chada.[421] She considered that it was relevant to add this, and that as a matter of fairness to Mr O'Brien, this issue should be investigated.[422] Dr Khan told the Inquiry that he also held the view that there was something to be explored in the failure of management to get to grips with the issues of concern at an earlier point in time, and it was for that reason that he was "satisfied" with the inclusion of the fifth part of the Terms.[423] The ToR were not ultimately shared with Mr O'Brien until 16 March 2017.[424]

221. Dr Chada told the Inquiry that her line of communication was with Dr Khan, not with the Trust's Oversight Committee, and that is why she wrote to him.[425] Dr Khan was asked about the sequence of events leading to the formation of the ToR. His evidence appeared confused and inconsistent. In his witness statement he expressed the clear understanding that the ToR, comprising five points, "were drafted and approved by oversight committee members" before being shared with him and that, when he saw them, he agreed with them.[426] He did not refer to the input of Dr Chada, nor to the communication from Ms Hynds asking him to agree the fifth Term. In his oral evidence, the existence of the email which had been sent to Dr Khan by Ms Hynds on 15 March 2017, adding the fifth issue as part of a final ToR, was drawn to his attention. He told the Inquiry he had no recollection of discussing the fifth term with Dr Chada.[427] Indeed, he did not discuss this issue with the Oversight Committee either.[428] It would appear that he made an assumption that this set of Terms had been approved by the Oversight Committee because that had been the process to date.[429] In this regard, Dr Khan's evidence is emblematic of the confusion that existed in relation to the role of the Oversight Committee and tends to suggest that, even at this important formative stage of this MHPS process, there was an absence of

421 WIT-23763, paragraph 1.20
422 TRA-03606, lines 7-12
423 TRA-03934, lines 3-14
424 TRU-285824 to TRU-285827
425 TRA-03609, lines 12-21
426 WIT-31962, paragraph 1.3(h). See also Dr Khan's remarks at WIT-31983, paragraph 11.1, where he reiterates this position
427 TRA-03932, lines 19-20
428 TRA-03933, lines 1-3
429 TRA-03933, lines 9-20

cohesion and good communication between those who had ordered the investigation (the Oversight Committee) and those who were charged with conducting it (Dr Chada) and overseeing it (Dr Khan).

222. We see nothing wrong with a Case Investigator, after she has commenced her duties, reaching the view that the ToR are deficient in some respect, and making representations to the Trust's decision-makers and obtaining their approval to change the remit; this scenario was expressly contemplated by the extant NCAS guidance.[430] However, we find that it was unnecessary and contrary to the purpose of the MHPS Framework to use the investigation to address the actions of management; the process is not intended to be used to examine whether a clinician was managed properly. Indeed this was accepted by Dr Chada in her evidence, although she explained that she considered it appropriate to cover the issue as a matter of fairness to Mr O'Brien and to highlight the issues.[431] We wish to be very clear that it is not our intention to be overly critical here. We do not suggest that this was not an important issue; it clearly was. In the context of a prolonged failure by Trust management to successfully address known issues with Mr O'Brien, we understand why Dr Chada and Dr Khan felt obliged to at least attempt to explore it. [432] It is, however, our clear view that the MHPS investigation was not the occasion to address this issue and that its inclusion resulted in the investigation becoming more time consuming, wider, and less concentrated than it needed to be. Moreover, it is difficult to understand the Oversight Committee's general delay in finalising and issuing the ToR when the issues requiring investigation were evident from, at least, the time of the Case Conference on 26 January 2017, if not before. More is said about this in the Governance chapter.

223. In parallel to the substantive investigation, as had been agreed at the Case Conference, monitoring arrangements were implemented in an effort to ensure Mr O'Brien was practicing safely. The arrangements (the 'Return to Work'

430 See NCAS 'How to conduct a local performance investigation' at WIT-41407 to WIT-41408
431 TRA-03620, line 25 to TRA-03621, line 4
432 TRA-03935, lines 8-18

arrangements) were developed by Mrs Gishkori and her team, with support from Ms Hynds.[433] They required strict compliance with the Trust's policies and procedures relating to triage, dictation, storage of documents and the management of private patients, and an agreement to comply with the monitoring processes.[434] The Oversight Committee envisaged that the plan would remain in force for the duration of the MHPS investigation.[435] The arrangements were approved by the Oversight Committee and presented to Mr O'Brien by Dr Khan and Ms Hynds at a meeting on 09 February.[436] There was a lengthy discussion regarding what the Trust expected on Mr O'Brien's return and Mr O'Brien knew what the Trust expected him to comply with on his return to work.[437]

224. At the same time, work to ascertain the full extent of the issues remained ongoing. On 03 March 2017, the consultants' review of the outcomes of undictated clinics "essentially has not started".[438] By 12 April, the consultants' review had resulted in 24 referrals being upgraded to Red Flag, three had been identified as SAIs, and the status of five further patients was unknown. However, there had been slower progress in respect of the undictated clinics as the work required in reviewing those cases was "significant".[439] By 15 May, review of the undictated clinics had been completed in respect of 161 of the patients affected, which Dr Chada would use as a sample for the purposes of completing the MHPS investigation.[440] On 07 June, the review of undictated clinics had completed, with 110 patients being added to the Review outpatient waiting list; 35 patients being added to theatre waiting lists; and three patients, in respect of whom the consultants had concerns, having had urgent appointments arranged.[441] The Inquiry recognises that this investigation took an extremely long time to reach conclusion as the chronology below sets out. It was a complex task undertaken by a clinical team under pressure.

433 TRA-03975 to TRA-03976
434 TRU-258703 to TRU-258707
435 WIT-31985, paragraph 12.7
436 TRU-00732 to TRU-00734
437 AOB-56118 to AOB-56146; TRA-03979, lines 26-28
438 TRU-267904
439 TRU-268080
440 AOB-01568
441 TRU-268814

225. The first witness interview was conducted on 15 March 2017. During March to June 2017, the Case Investigator met with all witnesses relevant to the investigation; Dr Chada took evidence from service managers, assistant directors, consultant urologists and other managers within the Trust.[442] All relevant witnesses, aside from Mr O'Brien, had been interviewed by 05 June 2017.[443] A drafting process followed each interview; alongside Ms Hynds, Dr Chada used the notes of her interview with each witness to produce a draft witness statement for their consideration, revision, and approval. She explained that some witnesses were anxious about their participation in the process and required "reassurance" and that some witnesses took time to add to their draft statement as they remembered additional points, or to provide clarification.[444] Some of the statements were not finalised until mid-September 2017.[445] Others remained outstanding until later in the process.[446] In total, witness statements were received from 14 witnesses, including Mr O'Brien.

226. Dr Chada acknowledged that the MHPS Framework suggests that the subject of the investigation should be interviewed first but explained that she had ruled this out in favour of hearing from other witnesses so that she could understand what was being said about Mr O'Brien before interviewing him.[447] In our view, this was not the best approach. Apart from the concern that Mr O'Brien had given preferential treatment to patients who had attended him in a private capacity (which he denied and has continued to deny), it ought to have been known at the commencement of the investigation that he accepted (or would accept, had he been asked) that there was an irrefutable factual basis for the other concerns which were the subject of the investigation, although he would have disputed that there was any culpability on his part. Put differently, it is inescapable that Mr O'Brien would have acknowledged that he had largely failed to triage Urgent and Routine referrals; that he had brought significant volumes of patient records

442 TRU-00671
443 TRU-00671; WIT-23764, paragraph 1.22
444 WIT-23764, paragraph 1.22
445 WIT-23764, paragraph 1.22
446 WIT-23766
447 TRA-03586, line 23 to TRA-03587, line 5

to his home and stored them there; and that he did not dictate records after every clinical encounter. Therefore, it seems to us that, had Dr Chada – guided by Ms Hynds – commenced the investigation by arranging a preliminary meeting with Mr O'Brien with the objective of establishing what was agreed and what was in dispute, it would most likely have been discovered that there was a significant measure of agreement around the facts of the issues which were causing the Trust concern. In turn, it would perhaps not have proven necessary to interview and obtain statements from so many witnesses, or the issues to be explored with witnesses could have been narrowed. Dr Chada's rationale for delaying the interview with Mr O'Brien, that she wished to be as fully informed as possible, was not helpful in maintaining momentum and establishing trust in the process.

227. Once all other witnesses had been interviewed, on 14 June 2017 Dr Chada wrote to Mr O'Brien, inviting him to a meeting on 28 June 2017 to provide a full response. Mr O'Brien requested that this be rescheduled and the first meeting with Mr O'Brien, therefore, took place on 03 August 2017.[448] Mr O'Brien was not provided with the statements of other witnesses before this meeting.[449] Dr Chada explained that:

> "Some of the witness expressed concern about Mr O'Brien seeing their statement. Others found being involved in the investigation difficult and needed reassurance."[450]

These statements were ultimately provided to Mr O'Brien prior to a second investigation meeting with him on 06 November 2017.[451] As a matter of fairness, at the very least, those statements which had been finalised should have been provided to Mr O'Brien in advance of the meeting of 03 August.

448 TRU-268953 to TRU-268955; TRU-268958; TRU-268986
449 AOB-01690
450 WIT-23764, paragraph 1.22
451 TRU-287818; TRU-283869; TRU-283887; TRU-287931; TRU-284020

228. At the meeting on 06 November 2017, Mr O'Brien indicated that he wished to provide additional comments on his first statement and the witness statements provided to him.[452] However, he advised that his:

> "priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period."[453]

On 20 November 2017, Ms Hynds provided an update to the Case Manager, indicating that "No further meetings are planned and a report will be completed as soon as possible for your consideration."[454] Ms Hynds conceded:

> "on reflection I along with Dr Chada should have insisted on a commitment from Mr O'Brien to prioritise the comments on his witness statements and return them sooner. Mr O'Brien was not expressing any urgency to get matters completed."[455]

The Inquiry agrees there was a need for Dr Chada and Ms Hynds to manage this process with greater firmness.

229. No such commitment having been sought, by February 2018, no further progress had been made in concluding the investigation. There seems to have been some confusion as to what the agreed next steps were. On 12 February 2018, Dr Chada advised Dr Khan that Mr O'Brien had:

> "explained he wanted time out to sort out his appraisal. So I think we are waiting for him to get back to us, rather than any delay on our part."[456]

However, on 15 February, Ms Hynds advised Mr Wilkinson, the Designated Board Member, that Mr O'Brien wanted to provide his commentary but:

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452 AOB-56285 to AOB-56293; TRU-00672
453 TRU-56287; TRU-00672, paragraph 4
454 TRU-261965
455 WIT-42085 to WIT-42086, paragraph 24.20
456 TRU-269355

> "had priorities prior to Christmas which would prevent him providing his comments. It was agreed that we would wait on receipt of these.
> I have not received any feedback from Mr O'Brien and it has been my delay in following this up with Mr O'Brien."[457]

Having been asked for his comments that same day, Mr O'Brien responded indicating that it was his understanding that he would receive notes of the meeting of 06 November 2017, following which he would reply with comments on all of the meetings but indicated that he would respond by 31 March 2018.[458] Ms Hynds required his response by 09 March, however that deadline was missed. Subsequent deadlines were set for 26 March and 30 March, after which the report would be finalised, however these were not adhered to either.[459] Mr O'Brien finally provided his comments on 02 April 2018.[460] The report was subsequently finalised and delivered to Dr Khan and was available to Mr O'Brien from 21 June 2018.[461]

230. Dr Chada's investigation report was detailed, totalling 45 pages and with 36 appendices.[462] The key findings in respect of each concern are summarised in the paragraphs which follow.

Triage

231. With regard to triage, the expectation was that Red-Flag referrals would be reviewed and triaged within 24 hours and that all triage would be completed within 72 hours, in line with the Regional IEAP Standards for Triage of Referrals to Secondary Care.[463] The investigation found that a number of people within the Trust were aware of the issue over a number of years and that a default process

457 TRU-261791 to TRU-261792
458 TRU-269358 to TRU-269359
459 TRU-00672 to TRU-00673; TRU-284042; TRU-269367; TRU-269372
460 TRU-284048
461 TRU-263994 to TRU-263995
462 TRU-00661 to TRU-00705
463 TRU-00675

had been introduced in response to Mr O'Brien's failure to return referrals.[464] There were 783 untriaged referrals identified, of which 24 warranted upgrading to Red Flag and five patients had cancer, with diagnoses delayed by between 151 days and 64 weeks.[465] Mr O'Brien accepted that he did not triage Routine or Urgent referrals during 2015 and 2016 as he did not have time to do so.[466] The report records that Mr O'Brien was "surprised that there were such a small number upgraded."[467] Dr Chada concluded that:

> "it was a widely known fact among some staff within the Acute Services Directorate, that Mr O'Brien's triage was often not returned"[468]

and that:

> "the responsibility for triage of the referrals was that of Mr O'Brien's."[469]

Patient Notes

232. The report records that 307 sets of patient notes were returned by Mr O'Brien to Trust premises on 03 January 2017.[470] Dr Chada identified that there was no Trust transport between CAH and South West Acute Hospital and that these notes were not returned.[471] Mr O'Brien was recorded as having stated that his storage of patient notes at home "didn't affect other specialties as he would always have returned the notes when requested" and that no detriment was caused to any patient.[472] In her findings, Dr Chada observed that "it was well known Mr O'Brien did not always return case notes" and that there was "no clear system for tracking notes through PAS" but that:

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464 TRU-00675
465 TRU-00676 to TRU-00677
466 TRU-00685
467 TRU-00686
468 TRU-00691
469 TRU-00693
470 TRU-00678
471 TRU-00678
472 TRU-00686

"No check or review was done to determine the extent of the problem in March 2016 or at any other time prior to this investigation."[473]

Mr O'Brien accepted that he kept notes at home. While 13 sets of notes were still missing, it was accepted that Mr O'Brien was not in possession of them.[474]

Dictation

233. It was found that dictation from 66 clinics had not been completed, dating back to November 2014 and affecting 668 patients.[475] A full review of the charts for each affected patient was undertaken by the consultant urologists; this took approximately six months to complete. The review revealed a number of different issues, such as multiple attendances without letters on file; delays in letters; and no entries on charts or on PAS.[476] Mr O'Brien accepted that 41 clinics were undictated and that his practice was to record outcomes at the end of attendances and explain these to patients.[477] Dr Chada found that there were 66 undictated clinics and 68 clinics with no outcome sheets.[478] It was found that, as Mr O'Brien was not using digital dictation, "there was no way of reporting on his dictation of clinics."[479] However, the report does not provide a breakdown of the review of notes performed by the consultant urologists.

Private Patients

234. Despite Mr O'Brien having initially been advised that the review of private patients only concerned TURP patients, a full review of his private practice was undertaken and 11 patients were identified who appeared to have had their procedures within much shorter timeframes than would have been expected, given their clinical priority, had they been HSC patients.[480] These cases were

473 TRU-00694 to TRU-00695
474 TRU-00696
475 TRU-00679 to TRU-00680
476 TRU-00679
477 TRU-00686
478 TRU-00696
479 TRU-00697
480 TRU-00680

reviewed by Mr Young, CL, who considered that nine of the 11 were found to have had no clinical reason for being treated within such a short time.[481] Whilst Mr O'Brien disputed the dates which, on the information available to the Trust, indicated the date on which the patients had been placed on the waiting list, Dr Chada nevertheless was:

> "not persuaded by the justifications provided by Mr O'Brien for why the 9 private patients highlighted above were seen in the timeframes outlined. I would conclude that these patients seen privately by Mr O'Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over HSC patient's [sic] with the same clinical priority."[482]

Management Actions

235. With regard to the fifth Term of Reference, Dr Chada found that senior managers were aware of issues with triage and the storage of notes prior to December 2016 but were unaware of issues relating to undictated clinics and private patients.[483] The investigation concluded that Mr O'Brien's failure to triage had resulted in potential harm for 783 patients and that his lack of dictation was "unacceptable practice."[484] Dr Chada ultimately considered that:

> "there were earlier opportunities to address concerns (prior to 2016) and these opportunities were not taken in a consistent, planned or robust manner."[485]

236. Dr Chada was clear that no concern had been raised about Mr O'Brien's "hands on patient care / clinical ability."[486] However, she noted that Mr O'Brien:

> "displayed some lack of reflection and insight into the potential seriousness of the above issues"

481 TRU-00680 to TRU-00681
482 TRU-00702
483 TRU-00702 to TRU-00703
484 TRU-00703 to TRU-00704
485 TRU-00704
486 TRU-00705

in failing to appreciate the impact of delayed diagnosis and failure to accept the importance of administration processes. Dr Chada felt that it was "appropriate and relevant to raise this with the case manager."[487]

Delay in the MHPS investigation

237. The decision to commence a formal MHPS investigation into Mr O'Brien's practice had been taken by the Oversight Committee on 22 December 2016. Despite the MHPS Framework envisaging that investigations would be concluded within a four-week time frame, and despite the Trust's assurances that the investigation process would be "as expeditious as possible",[488] the MHPS investigation concerning Mr O'Brien did not conclude until October 2018, when the Case Manager, Dr Khan, delivered his determination and recommendations. It must only be in exceptional circumstances that a workplace process directed to inquiring into the performance of an employee should take almost two years to finalise. However, this was not an unusual or exceptional case; in many ways it was a straightforward case in that the basic facts were, largely, widely agreed. Indeed, many of the performance issues were known and, therefore, ought not to have required extensive investigation. For example, Mr O'Brien accepted from the outset that he had retained a significant number of patient files at home, that he had not triaged a large number of Urgent and Routine referrals and that he had not dictated on all of his patient encounters.[489] In a healthcare environment, where patient safety must be safeguarded, it is even more important to ensure that such processes run smoothly and without unnecessary delay.

238. There were a number of practical hurdles which were not conducive to expediting the process. Dr Chada agreed to undertake the role of Case Investigator in addition to her usual clinical and managerial responsibilities. She was not provided with additional secretarial or administrative support, nor was she

487 TRU-00705
488 TRU-00719
489 TRU-00708 to TRU-00711

afforded 'protected time' which might have permitted her to focus on the investigation to the exclusion of her other commitments. Self-evidently if an investigation is to be resourced in this way, there will be times when the investigator will be unable to press forward with the investigation without causing detriment to their clinical practice. It would be unreasonable to expect a practitioner to place clinical commitments to one side; indeed, Dr Chada provided an example of an occasion where she clearly could not do so, meaning that the investigation was interrupted.[490] Equally, the availability of clinicians and managers who were required to participate in an interview with Dr Chada will have been constrained by other responsibilities. Dr Chada was clear that she did not want clinicians to have to cancel theatres or clinics, meaning that she had to be flexible and work around their availability.[491] This was an entirely understandable, and reasonable, approach in the circumstances.

239. In these respects, Dr Chada's experience was far from unusual. The Inquiry understands that those who undertake the MHPS Case Investigator role for their employer generally do so as volunteers and must fit the investigation in around their other professional commitments.[492] It is to the enormous credit of Dr Chada, and the others that do so, that they agree to take on such roles. In most cases, as was the case here, the Case Investigator will receive technical support from a HR professional, but the burden of leading the investigation and carrying out the important duties of determining its direction, questioning witnesses, formulating conclusions, and constructing the report predominantly falls upon the Case Investigator. Later in this section we suggest some ways in which this problem can be substantially mitigated.

240. Another factor which contributed to delay was the need for other clinicians and operational managers to conduct a series of parallel investigations. As Dr Chada explained, these inquiries were necessary:

490 WIT-23766, paragraph 1.27
491 TRA-03638, lines 24-27
492 TRA-03571 to TRA-03573; TRA-03588; TRA-03719 to TRA-03720; TRA-03868; WIT-32001

> "so that concerns [which were the subject of her investigation] could be properly quantified and understood."[493]

She further explained the scale of the task, which involved:

> "checking each set of case-notes returned by Mr O'Brien from his home to see if management plans had been actioned and to dictate on letters as needed, to look at where private patients were being added to waiting lists and assess if the level of prioritization was appropriate, and to go through all the untriaged referral letters which had been uncovered during Mr O'Brien's Consultant of the Week rotas."[494]

This work was conducted by senior clinicians who also had services to run, and this, in turn, further compounded the delay.

241. It was necessary to advance these inquiries, not only to provide a specific factual context for Dr Chada's investigation and to ensure that appropriate questions could be addressed to Mr O'Brien,[495] but, also, to help to determine whether there was any risk to patients which should be addressed. Some of these tasks had commenced before Dr Chada commenced her work, but none of them had been completed at that time. Gradually, information concerning the impact of the shortcomings of Mr O'Brien's performance was provided to Dr Chada. However, it was not until October 2017, when she received an analysis prepared by Mr Young in relation to the private patient issue, that this parallel work was completed. Plainly, until Dr Chada had received this information, she could not complete her interview with Mr O'Brien.

242. The Inquiry considers that Mr O'Brien ought to have been interviewed at the start of the investigation, and again after the other witnesses had given statements.

493 WIT-23780, paragraph 12.1
494 WIT-23768, paragraph 1.37
495 WIT-23778, paragraph 11.1

Dr Chada took over this investigation after the initial stage and this may explain why things did not happen in that way.

243. However, there were other significant factors which contributed to delay in the investigative process which could have been better-managed. The vital interaction between the investigation and Mr O'Brien was characterised by poor communication, an inability to arrange timely meetings, a failure to set effective deadlines and tolerance of slippage. On occasions it appeared that Mr O'Brien was allowed to determine when he would be interviewed and when he would respond to the requirement to provide a statement.[496] For example, when Dr Chada had agreed to Mr O'Brien's suggestion that they should have their first meeting on Saturday 01 July 2017, Mr O'Brien indicated that it was his preference to put the meeting back until after the holiday period; this was also agreed.[497] Dr Chada accommodated this at least in part because she did not wish to apply pressure on Mr O'Brien who had been receiving medical treatment.[498] A second meeting did not take place until 06 November 2017 for reasons outside of Dr Chada's control. However, after that meeting she acquiesced in his wish to prioritise work on his outstanding annual appraisal, at the expense of his focus on that which needed to be done to complete his engagement with the investigation.[499] On one level this is understandable as the appraisal process is important and Dr Chada wished to be seen to be fair to Mr O'Brien and relieve him of some pressure, however, this was an appraisal being done in November 2017 covering the year ending in November 2016, therefore the cycle of appraisal was very delayed and prompt completion was not essential by this point. Also, Dr Chada could have sought the Medical Director's advice regarding the importance of prioritising the appraisal and this may have prompted the Medical Director to consider whether an appraisal discussion to reflect on the investigation should be mandated. Dr Chada's attempt to be fair to Mr O'Brien was flawed and at the expense of an MHPS

496 At TRA-03654, lines 25-27, Dr Chada commented that she eventually recognised that Mr O'Brien was trying to exert a measure of control, and to manage the timeframe
497 TRU-268959 to TRU-268960
498 TRA-03654, lines 10-20
499 AOB-56287; WIT-23766, paragraph 1.29

investigation process which, by this point, had been ongoing for almost 12 months. This approach was too lenient in the circumstances and Dr Chada should have sought to impose greater discipline on the investigation timetable. Mr O'Brien should have been required to sign up to a strict commitment to finalise his responses by a specific date in early 2018 in return for the flexibility which had been extended to him. However, no deadline was fixed. Rather, Dr Chada was left with a somewhat vague understanding that Mr O'Brien would revert to her with his commentary by an unspecified date in January and, when she had not heard from him, she did not take immediate action.[500]

244. The Inquiry has seen some evidence of those who held official roles within the MHPS process having raised the issue of delay.[501] However, at no stage did anyone intervene with a view to discussing practical ideas to overcome the logjam. Dr Chada explained that, although Dr Khan regularly sought updates, he did not suggest any methodology or assistance that could be applied in order to move matters on quicker.[502] Dr Khan acknowledged that he:

> "could have or should have been more proactive in terms of pushing this investigation through the process and getting it finished."[503]

He explained that he felt a need to avoid being seen to be interfering with the investigation and to allow that part of the process a degree of autonomy or independence.[504] We consider that this was understandable, particularly in light of his lack of experience with the MHPS Framework. It is our view that those with greater experience, particularly those who constituted the Oversight Committee, should have ensured that this investigation was resourced to proceed at a much swifter pace. We also consider that the Medical Director could have done more to support Dr Chada in progressing the investigation. It is also our view that the

500 WIT-23766, paragraph 1.29
501 WIT-23762, paragraph 1.15; WIT-23775, paragraph 8.5; WIT-23776, paragraph 9.1; WIT-31975, paragraph 7.3(c); WIT-91937 to WIT-91938, paragraph 3
502 TRA-03585, line 20
503 TRA-03869, lines 17-19
504 TRA-03864, lines 5-6

Chair of the Oversight Committee should have been available to provide either methodology or assistance to move these matters forward at a quicker pace.

245. Dr Chada recognised that an investigation lasting 15 months is not helpful to either the person under investigation or the Trust.[505] However, she characterised the investigation concerning Mr O'Brien's practice as "complex and far-reaching" and suggested that it was "frankly totally unrealistic" to comply with the timeframe suggested within the MHPS framework.[506] She told the Inquiry that, in the four MHPS investigations in which she had acted as Case Investigator prior to the O'Brien case, it was "very difficult to keep to the time scales" and observed that, where she was expected to perform the role of Case Investigator whilst also trying to manage a busy clinical practice, MHPS could not be considered "fit for purpose."[507] We entirely agree with Dr Chada and other witnesses who have suggested that the four-week indicative time frame prescribed by the MHPS framework is not realistic. We would go further and suggest that, in any case which is pursued under the MHPS framework, and which requires even a modest investigation, this timeframe is likely to prove impossible to comply with. This timeframe should be removed from the text of the framework, even if it is only there as an aspiration, because it serves only to create an unrealistic expectation, and a sense of frustration and grievance, when it cannot be delivered.

246. Dr Chada was well-qualified to perform the role of Case Investigator, having previously completed relevant training. Indeed, just as she commenced her investigation into Mr O'Brien's practice in March 2017, she took part in a Case Investigator's Training Workshop, which explored the investigation role and responsibilities under the MHPS Framework.[508] Dr Chada explained that she found this training "very helpful" because it expanded on the very limited description of the role of Case Investigator set out in the MHPS document.[509] In addition to that training, Dr Chada also had practical experience of MHPS, having

505 TRA-03573, lines 12-14
506 WIT-23762, paragraph 1.17
507 TRA-03567, line 7 to TRA-03571, line 17
508 WIT-23771 to WIT-23772, paragraph 5.3; WIT-23790 to WIT-23797
509 TRA-03564, line 23 to TRA-03565, line 16

performed the Case Investigator role in other MHPS investigations.[510] In her evidence she described those investigations as having addressed "complex and significant issues".[511] When conducting the investigation concerning Mr O'Brien she worked with and received guidance from Ms Hynds (Employee Relations) whom she described as also having "extensive experience of using the Maintaining High Professional Standards Framework."[512]

247. Despite having had the benefit of a well-qualified and experienced Case Investigator and HR professional, the MHPS investigation concerning Mr O'Brien nevertheless took some 15 months to complete. As highlighted above, there were some opportunities which were not taken which would have improved the efficiency of the process and, for this, Dr Chada must bear a share of the responsibility. However, the responsibility was by no means hers alone. The delay in this investigation was, primarily, a reflection of the Trust's arrangements for resourcing such investigations and the constraints of those arrangements, particularly in terms of coordinating time in job plans. In this regard, the Inquiry wishes to expressly recognise the significant demands placed upon Dr Chada and to commend her for undertaking the role of Case Investigator, on a voluntary basis, in addition to her significant clinical commitments.[513] Dr Chada properly pointed out that there may be a need to formalise the main roles within an MHPS process (or, indeed, within an SAI review process), especially in those cases which are likely to prove particularly time consuming or where it might be anticipated that the subject matter of the investigation will attract the interest of an inquest or public inquiry.[514] The Inquiry agrees and would further suggest that the roles should be formalised in respect of cases which may form the subject of any other form of legal hearing.

510 WIT-23770, paragraph 4.2; WIT-23773, paragraph 6.3
511 TRA-03567, lines 4-7
512 WIT-23771, paragraph 5.1
513 In evidence, Dr Chada explained the responsibilities she held as a Consultant Psychiatrist and as AMD. She also explained the demands placed upon her as Chair of SAI reviews within and outside the Directorate in which she was employed, in addition to the role of Case Investigator in Mr O'Brien's case: see TRA-03569, line 25 to TRA-03571, line 17.
514 WIT-23786 to WIT-23787, paragraph 18.2

248. Similarly, the Inquiry notes Dr Khan's evidence about the adequacy of the training he received in respect of his role as Case Manager. Dr Khan was a Consultant Paediatrician and the AMD within the Children and Young People Directorate of the Trust. When he was approached by Dr Wright to take on the role of Case Manager, he had no experience of the MHPS Framework, although, as AMD, he had occasion to manage medical staff performance concerns pursuant to the Trust's Guidelines.[515] He advised Dr Wright of this and arrangements were made for him to attend MHPS training in March 2017.[516] Dr Khan explained that the training he received focused on the role of Case Investigator, as opposed to the duties of Case Manager.[517] He indicated that the training was useful to the extent that it provided him with a general understanding of the MHPS framework but, on reflection, considered that he:

> "wasn't fully equipped to carry out such a complex MHPS case investigation."[518]

In particular, he considered that it would have been important to have had background knowledge of the clinical domains which were developed and delivered in the specialism and out of which the concerns which were subject of the investigation, had arisen.[519] He considered that, beyond training, there was a need for employers to help their practitioners develop what he referred to as "skills", "peers", "competencies", and "expertise" to perform the Case Investigator or Case Manager role in even simple MHPS cases.[520] He supported the idea of identifying a pool of practitioners who might be called upon to perform MHPS duties, but if that was to be pursued he recognised that there would be a need to resource ongoing training, support and development.[521] The Inquiry agrees.

515 WIT-31973, paragraphs 6.1 and 6.2
516 WIT-31973, paragraphs 6.3 and 6.4
517 TRA-03856; WIT-32210
518 WIT-32000, paragraph 24.2(a)
519 TRA-03858, line 27 to TRA-03859, line 4
520 TRA-03857, lines 10-24
521 TRA-03858, lines 1-6

249. In our view, it is unrealistic to expect investigations to conclude promptly, less still to conclude within the prescribed four-week timeframe, unless the investigation team is afforded sufficient time to conduct the investigation and arrangements are made to make relevant witnesses available so that they may participate promptly in the investigation. We are satisfied that the commitment of additional resource and support would have significantly improved the MHPS investigation concerning Mr O'Brien. In all MHPS investigations, the relevant Trust must, at an early stage, consider how the investigation is to be resourced. There cannot be a one size fits all approach. In smaller, single-issue cases it might well be appropriate to apply the model used here, where an experienced and appropriately trained clinician can take on the investigation with the assistance of a HR professional. But there will be other cases which will benefit from the deployment of more than one external investigator, perhaps professionally trained in the conduct of investigations, and assisted by a HR professional. The Inquiry recognises that it may be that there is a need to share expertise across HSC Trusts in Northern Ireland in this regard.

250. We share the view expressed to us by a number of witnesses, including Dr Chada and Dr Khan, that MHPS investigations must be supported by building specific, protected time into the job plans of those charged with significant responsibilities - including the Case Investigator, Case Manager, and HR professional - so that they can fulfil their duties optimally and without adversely impacting their clinical commitments. They must be enabled to bring focus to these important roles, build momentum and continuity, whilst reducing the risk of being distracted.[522] Additionally, every MHPS team should be assigned an administrator who can deal with the main clerical demands of the process, rather than expecting that work to be performed by the HR professional and on occasion the Investigator.[523]

522 WIT-23784, paragraph 16.1; WIT-31123, paragraph 70.2; TRA-03886, line 29 to TRA-03887, line 2

523 At TRA-03642, lines 6-26, Dr Chada provided the Inquiry with an eloquent description of an investigation which struggled under the weight of its administrative demands.

251. Aside from the issue of resourcing, it is not lost on the Inquiry that the nature of Mr O'Brien's engagement with the investigation also significantly contributed to its length. The Grievance Panel that dealt with the Grievance lodged by Mr O'Brien after the MHPS investigation stated Mr O'Brien's request to prioritise his appraisal:

> "suggests that Mr O'Brien considers that he has considerable authority to manage the timeframe of the MHPS investigation himself which is not the case. It is our opinion that both parties share responsibilities for progression. … Mr O'Brien was not inclined to progress and he controlled this by his inaction. … there ought to have been a more assertive management of Mr O'Brien even thought [sic] he would have been unlikely to have welcomed that."[524]

It was not appropriate for Mr O'Brien, the doctor subject to the investigation, to dictate to the Trust that other matters were of a greater priority than contributing to the investigation. This should have been better managed, both by the Case Investigator and by Trust management, who should have mandated him to so engage.

252. The Review of the Stage 1 Grievance which reported in June 2021 found at paragraphs 5.8 and 5.9 that:

> "there was a contribution to the delay both by the Trust and Mr O'Brien. In relation to concluding the MHPS investigation, we find that this should have been concluded in a timelier manner. If this investigation were as serious as it is purported to be the investigator should have been given time out of her normal commitments to carry out the interviews necessary and have the report completed. This did not happen … There was no one pressing the completion of these matters irrespective of the breach of the published timeframes"

524 TRU-158652; TRU-158674 to TRU-158675 (Extracts from Response to Stage 1 Grievance dated 26 October 2020)

and that:

> "while one might argue that the parties are equally culpable, the Trust as the Employer has the responsibility [sic] take control of the process and the timescale for completion."[525]

The Inquiry agrees that it was, ultimately, the responsibility of the Trust to ensure that an investigation impacting on patient safety concluded in a prompt and fair manner.

Dr Khan's case determination (July 2018 – October 2018)

253. Dr Khan received Dr Chada's report in June 2018, on the eve of the holiday period. He had planned annual leave for the month of July. His planned absence on leave, when added to his additional responsibilities as Acting Medical Director, caused him to consider whether he had the capacity to continue to carry the duties associated with the Case Manager's role. He has explained that:

> "I was very mindful of my competing demands as senior management team and Trust Board member and its responsibilities."[526]

He therefore engaged in discussions about this with his line manager but, despite these pressures, the Oversight Committee refused to sanction a change.[527]

254. On 10 July 2018, Mr O'Brien submitted a detailed section-by-section response to Dr Chada's investigation report.[528] Mr O'Brien again acknowledged that he had not been undertaking non-Red Flag triage, stating that:

525 TRU-158807; TRU-158814 to TRU-158815
526 WIT-32000, paragraph 24.2(b)
527 WIT-31990, paragraph 17.9; WIT-32233 to WIT-32234
528 AOB-01879 to AOB-01895

"there are steps that I could have taken to more clearly state that I was not undertaking triage of routine or urgent referrals."[529]

Mr O'Brien's view was that the issue regarding the storage of charts was equally well known and that the number of patients in respect of whom dictation had not been completed totalled 189 which was "markedly less than" what the Investigator was told and in respect of whom he was "unaware of harm or risk of harm".[530] With regard to private patients, Mr O'Brien claimed, amongst other representations, that no comparative analysis was undertaken as part of the investigation.[531]

255. On returning from annual leave, Dr Khan deliberated upon the investigation report through the months of August and September.[532] Before drafting his determination he read the investigation report and supporting evidence; he read a 'factual accuracy' statement prepared by Mr O'Brien; he shared the investigation report and met with the Trust's Chief Executive, Mr Shane Devlin, and the Director of HR, Ms Toal; and he took advice from Dr Lynn.[533] He further gave consideration to the MHPS Framework and the GMC publication, *Good Medical Practice*.[534]

256. In his engagement with Mr Devlin and Ms Toal, Dr Khan discussed the findings of the investigation.[535] He also sought their advice. The advice which he received appears uncontroversial: that he should construct his report and recommendations around the evidence presented to him and follow the MHPS framework and 2010 Guidelines. The input of the Chief Executive at that stage of the process is not provided for within the MHPS Framework, nor the 2010 Guidelines. Nevertheless, given his inexperience, his decision to engage in a conversation of the investigation's findings, to seek advice from these sources

529 AOB-01893, paragraph 7
530 AOB-01894, paragraph 3
531 AOB-01894
532 WIT-31965, paragraph 1.4(j)
533 NCAS confirms classification as conduct: TRA-04447. Letter to confirm call: WIT-53452
534 TRA-04024, line 25 to TRA-04025, line 13
535 WIT-31965, paragraphs k and l

regarding the preparation of a report, and to assist him to shape his ideas regarding how to frame recommendations that were critical of management in the Trust, was understandable.

257. Dr Khan read the 'factual accuracy' statement submitted by Mr O'Brien and recognised that it presented a challenge to Dr Chada's findings in a number of respects.[536] By way of example, we have noted that Mr O'Brien provided material and an analysis which challenged Dr Chada's finding that he had failed to provide a dictated record in relation to 66 clinics. Rather than engage with this material, and perhaps check with Dr Chada to assess her understanding of the issue, Dr Khan seemingly ignored Mr O'Brien's submission and proceeded to conclude:

> "It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien accepts this."[537]

258. Self-evidently, Mr O'Brien did not accept this finding of fact. He actively disagreed with it and hoped, by the provision of information, that he could demonstrate that it was inaccurate. There was absolutely no basis for Dr Khan recording that Mr O'Brien accepted the finding. When challenged about this by Counsel to the Inquiry, Dr Khan advanced a number of unsatisfactory explanations for his approach. These included that he had been advised by the Chief Executive and the Director of HR that he had "to take the evidence provided by the investigation team"[538] and that the precise numbers did not really matter as there were sufficient numbers to establish the case that Mr O'Brien was failing in his duty to provide a dictated outcome from a large number of clinics.[539]

259. Ultimately, if belatedly, Dr Khan conceded that he should have reflected Mr O'Brien's efforts to address issues of factual inaccuracy in his report, even if he considered that any inaccuracy had no significant impact on the overall thrust

536 TRA-04026, lines 6-9
537 AOB-01917, paragraph 3. (a)
538 TRA-04030, lines 11-14
539 TRA-04034, line 28 to TRA-04035, line 3

of the conclusions of the investigation report, or his determination.[540] The important point is that investigation reports should be as accurate as possible and, whilst there may be room for differences of opinion about the precise number of cases which might be involved or patients affected, it is an important function of the Case Manager to try to resolve any discrepancy, or at the very least, to acknowledge its existence. Further, if Dr Khan was provided with advice that he should simply work with the conclusions provided by the investigation team, that was the wrong advice. The MHPS Framework provides a facility for dealing with alleged factual inaccuracy and it should be used by Case Managers to deal with disputes. Investigators can make mistakes and it is incumbent upon Case Managers to take steps to ensure that appropriate questions are raised, rather than assert that a finding was accepted when it clearly was not.

260. Upon completion of his report, Dr Khan sent a copy to Mr Devlin and Ms Toal and notified Mr O'Brien that the determination was ready.[541] On 01 October 2018, a meeting took place at which the determination was disclosed to Mr O'Brien.[542]

261. In his Determination, Dr Khan outlined that he had considered Dr Chada's investigation report along with Mr O'Brien's response and determined that three actions were required:

(i) "an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties." This action plan would be reviewed and monitored by the Clinical Director and Assistant Director with escalation to the Associate Medical Director. The plan would cover "any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan".[543]

(ii) In light of the "systemic failures by managers at all levels, both clinical and operational," Dr Khan recommended that the Trust conduct "an

540 TRA-04036, lines 4-8
541 WIT-31966, paragraphs 1.4(o) and (p)
542 WIT-31966, paragraph 1.4(q)
543 AOB-01921

independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."[544]

(iii) Dr Khan determined that issues with Mr O'Brien's conduct had been identified which required consideration by a conduct panel.[545] Dr Khan noted Mr O'Brien's failure to adhere to aspects of Good Medical Practice, the wider systemic failings and the potential that actual harm had occurred to patients. Nevertheless, he considered that there was no requirement for a formal consideration by NCAS, a referral to the GMC, nor a clinical performance panel as "there are no concerns highlighted about Mr O'Brien's clinical ability."[546]

262. Dr Khan ruled out the need for formal consideration by NCAS, or the need for consideration by a clinical performance panel, characterising Mr O'Brien's failings as 'administrative', albeit that those failings had caused harm to some patients and placed others at risk of harm.[547] He also ruled out the need to make a referral to the GMC at that time, observing that Trust processes should first be concluded.[548] Dr Khan explained that he was not ruling out the need for a GMC referral altogether but, rather, he understood that a hearing before a conduct panel would take place first and, if appropriate, the conduct panel could make a referral at the conclusion of its deliberations.[549] He further explained to the Inquiry during his evidence that, as it transpired, when the GMC's Employer Liaison Adviser reviewed the MHPS report, she considered the threshold for referral had been met and the process was, thereafter, initiated by Dr Maria O'Kane (Medical Director of the Trust) in early 2019.[550] The matters identified during the investigation were sufficiently serious as to necessitate taking further

544 AOB-01923 to AOB-01924
545 AOB-01921 to AOB-01922
546 AOB-01923
547 AOB-01923
548 AOB-01923
549 TRA-04056, lines 2-5
550 TRA-04071, lines 8-20; AOB-60016

action. A referral to the GMC could, and should, have been made by Dr Khan at the time of finalising his case determination.

263. Dr Khan considered, albeit with a degree of uncertainty and hesitation, that his role as Case Manager ended with the delivery of his determination and that, therefore, responsibility for the implementation of these recommendations lay elsewhere.[551] We consider that his view of this is undoubtedly correct. Ownership of the MHPS process lay with the Oversight Committee, led by the Medical Director who, in turn, reported to the Chief Executive. It was their responsibility, individually and collectively, to ensure that the recommendations put forward by Dr Khan were appropriately considered and, if applicable, resourced and implemented.

264. Immediately after receiving the case determination, Mr O'Brien telephoned NCAS for advice and alleged that the Trust has misled NCAS.[552] He requested a number of documents from the Trust, including Oversight Group minutes and correspondence from NCAS in 2016.[553] He also had a series of phone calls and communications with NCAS.[554] Dr Khan was also in discussion with NCAS and the possibility of setting up a meeting between NCAS, Mr O'Brien and the Trust was discussed. This was eventually discounted because the Trust had proposed a conduct hearing as a first step and Mr O'Brien was disputing this as a valid action. Following his discussions with NCAS and receipt of the documents from the Trust, Mr O'Brien wrote to Dr Khan on 02 November 2018 to express his:

> "alarm to discover the nature of the activities and conduct of senior Trust management in 2016 related to concerns pertaining to my administrative practice"

551 WIT-31997, paragraph 21.1
552 WIT-53461 to WIT-53462
553 TRU-261998 to TRU-261999
554 WIT-53452 to WIT-53453

and concern that relevant minutes of Oversight Committee meetings were not disclosed to the Case Investigator.[555]

265. One of Mr O'Brien's concerns related to the lack of transparency and communication with him as a practitioner during the whole process. This was discussed with NCAS in oral evidence in the context of their view that advice letters and discussions with NCAS should, if possible, be shared openly with practitioners. They indicated that they now routinely advise this in writing, but that practice was not uniformly adopted in 2016[556] The Inquiry considers that failure to do this presented a problem and a missed opportunity for the Trust, for Mr O'Brien and ultimately for patients. The viewpoint of practitioners and their clinical managers is often misaligned, but sharing the information openly allows a better chance of resolution.[557]

266. In mid-November 2018, there were suggestions that members of Mr O'Brien's family were contacting clinical managers within the Trust about the investigation.[558] Dr Khan wrote to Mr O'Brien, stating "This is entirely inappropriate and must cease immediately" and advising that he had informed staff not to engage with Mr O'Brien's family members if approached in such a way.[559]

267. At the same time, the Trust was taking steps to convene a conduct panel.[560] However, on 30 November 2018 Mr O'Brien lodged a written Grievance with the Chief Executive in which he requested that:

> "The Trust should immediately confirm that no steps will be made to bring these matters to a Conduct panel before this grievance has been resolved."[561]

555 TRU-262004 to TRU-262005
556 WIT-53490 to WIT-53491; TRA-04278
557 TRA-04278
558 TRU-251964
559 TRU-279201
560 WIT-42097; TRU-289017
561 See AOB-02064 at AOB-02026 to AOB-02065; TRU-289122 to TRU-289123

The grievance alleged that the Trust had mishandled concerns since 2016, had failed to follow its own policies and procedures, had committed material breaches of contract, and had "wrongly classified the issues of concern as Misconduct."[562] In this regard, Mr O'Brien relied on the 2010 Guidelines, which state that:

> "If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member."[563]

The Stage 1 Grievance Panel reported on 26 October 2020.[564] This was, in turn, subject to a review prepared by the Assistant Medical Director of the Western Health and Social Care Trust (WHSCT), which concluded in June 2021. By this time Mr O'Brien, having submitted his request to retire from practice, was no longer employed by the Trust and additional concerns had emerged.[565]

268. In the case determination, Dr Khan set out his view that it was unnecessary to exclude Mr O'Brien from the workplace because he had "successfully worked to the agreed action plan during the course of the formal investigation."[566] He did, however, take the view that:

> "in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties."[567]

Dr Khan explained to the Inquiry that he considered it to be important that the plan should have input from Mr O'Brien so that he "owned" the plan.[568] The plan

562 AOB-02027; AOB-02054, paragraph 2.9.4
563 TRU-83695, Appendix 3
564 TRU-158652 to TRU-158686
565 TRU-158807 to TRU-158818
566 AOB-01921, paragraph 2.b
567 AOB-01921, paragraph 2.a
568 TRA-04050, line 23 to TRA-04051, line 5

was to be reviewed and monitored by those closest to the urology service, namely the CD and the Assistant Director within Acute Services, with escalation to the AMD and the operational Director should any concerns arise.[569]

269. Dr Khan was clear that the action plan should be directed to addressing patient-related administrative duties, and that there should be an agreed, balanced job plan to include appropriate levels of administrative time and an enhanced appraisal.[570] When asked about this during his evidence to the Inquiry, Dr Khan explained that, in terms of its scope, there was a need for a new action plan (further to the Return to Work Plan)[571] to "cover broader elements of Mr. O'Brien's practice", particularly taking into account the concern that a poor administrative practice can place patients at risk.[572] This was never done. Dr Khan was asked by Counsel to the Inquiry to set out his understanding of who would be responsible for taking the plan forward. In response, he indicated that it would have been necessary for the Acute Directorate, the HR Directorate and the Medical Director's Office to combine their efforts to produce an effective arrangement, with the Chief Executive's Office performing an oversight role.[573]

270. The Inquiry has not seen any evidence of a new action plan having been put in place, nor does there appear to have been any discussions with either Mr O'Brien or PPA with regard to same. There is also no evidence to suggest that Mr O'Brien's job plan was reviewed around this time. Dr Khan was aware that a new action plan was not developed in conjunction with PPA but was unable to explain the difficulty. He suggested that the HR Directorate had taken a decision that the revised action plan could not be taken forward pending completion of the Grievance which had been lodged by Mr O'Brien.[574] We do not consider that Mr O'Brien's filing of a Grievance ought to have in any way hindered the implementation of a revised action plan. In any event, in default of a new action

569 AOB-01921
570 AOB-01921
571 See Medical Management and Leadership chapter, paragraph 117 – where the Return to Work plan is discussed
572 TRA-04051 to TRA-04052
573 TRA-04052, lines 22 to TRA-04053, line 7
574 TRA-04053, lines 12-14

plan having been agreed, it was Dr Khan's understanding that the original Return to Work Plan from February 2017, remained in place and that it was a matter for the CD (at that time Mr Ted McNaboe), in conjunction with the HOS (Ms Corrigan) to continue to provide assurance until a review of the existing action plan could be completed.[575] What is missing from this explanation, and what has never been adequately explained to the Inquiry, is why there was a failure to commence a process of developing a new action plan. Following the case determination, the development of a revised action plan was a fundamental requirement to ensure that Mr O'Brien could practice safely within the Trust. The failure to develop one is inexcusable and served to undermine the findings of the MHPS investigation. It was incumbent on the Oversight Committee who commissioned MHPS to take steps to ensure that a new action plan was developed.

271. A further action point identified by Dr Khan related to the need for a conduct panel to consider the issues identified with Mr O'Brien's practice. In his evidence before the Inquiry, Dr Khan appeared to be in no doubt about how to interpret what had been occurring in Mr O'Brien's practice; in his view, there were a "number of elements" in respect of which there were failures to perform administrative duties, failures to comply with "known, standardised practices, policies and procedures", as well as a failure to "inform the wider system" what was happening. [576] In his case determination, Dr Khan identified five specific concerns which merited consideration by a conduct panel:

i. Failing to undertake non red flag triage, thereby putting patients at risk of harm.
ii. Failing to properly make it known to his line manager/s that he was not undertaking all triage.
iii. Knowingly advantaging his private patients over HSC patients.
iv. Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

575 WIT-31998, paragraph 21.8
576 TRA-04055, lines 12-17

v. Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.[577]

272. Importantly, in the case determination, Dr Khan also addressed the failings of management and systems which had the effect of enabling Mr O'Brien to behave as he did:

> "The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.
>
> Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien."[578]

273. In his evidence to the Inquiry, Dr Khan elaborated upon his thinking, emphasising that the issues with Mr O'Brien were known to many in the operational, clinical and medical leadership roles but "they were not escalated, they were not addressed to the full extent."[579] He explained that there "are so many levels of safety netting," including a professional governance structure, a clinical governance structure and operational managers, and, yet, he concluded, the Trust had not been "able to protect patients."[580] Dr Khan considered that, at that time, there was a need to review medical management and medical leadership structures and a need to improve assurance arrangements within the Trust.[581]

577 AOB-01922
578 AOB-01923, paragraph 6
579 TRA-04057, lines 11-18
580 TRA-04060, lines 2-3
581 AOB-01923 to AOB-01924, paragraph 6

274. It is the view of the Inquiry that the conclusions reached by Dr Khan in his case determination, in respect of the failures of management at all levels, were entirely justified. Having identified the problem, Dr Khan advanced a recommendation in the case determination which, he hoped, would enable the Trust to learn from its experiences.[582] He called upon the Trust to initiate:

> "an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."[583]

275. When asked by the Inquiry about the wording he adopted in formulating his recommendation that the Trust should undertake an "administrative review" Dr Khan accepted that the wording perhaps did not reflect the range of issues he was concerned about.[584] The Inquiry is of the view that the use of the term 'administrative' was unfortunate. As discussed further in the Governance chapter, this was eventually to be interpreted as a review of administration processes, rather than the review of management processes that Dr Khan had envisaged.

276. In evidence, Dr Khan emphasised the importance of an independent dimension to any review, explaining that bringing in a "fresh pair of eyes" from outside the Trust would be "more useful" if the goal was to extract meaningful learning from the process.[585] He considered that there was an urgency to commencing the review, just as there was an urgency to addressing the requirement for a fresh action plan and the establishment of a conduct panel, however each of these initiatives were suspended because Mr O'Brien had lodged a Grievance.[586] Dr Khan was clearly uncomfortable with the fact that the Grievance became the excuse for not taking these matters forward with the required urgency and

582 AOB-01923 to AOB-01924, paragraph 6
583 AOB-01923 to AOB-01924, paragraph 6
584 TRA-04081, lines 1-6
585 TRA-04061, line 27 to TRA-04062, line 3
586 TRA-04062, lines 8-21

expressed his view that, at the very least, the independent review could have "easily" moved forward, despite the need to process the Grievance.[587] Dr Khan was correct. There is no reason why the existence of the Grievance should have impeded the conduct of an urgent review. Indeed, there is every good reason why it should have gone ahead immediately.

277. As it transpired, the Trust took initial steps to establish a review process in 2020 before completing the Grievance, just a few months prior to Mr O'Brien's leaving the Trust.[588] Dr Khan was consulted about the terms of reference and advised the Medical Director's Office that he considered the terms, as drafted, to be excessively narrow and that they failed to address his concern that the problems with systems and management were not restricted to the urology service, but permeated the Acute Directorate at many levels.[589] He was not approached again in relation to the ToR. In October 2020, the draft findings of the Review were shared with Dr Khan.[590] The findings amounted to two pages. Dr Khan explained to the Inquiry that, when he saw what had been produced, he was "shocked" and the content was "so limited" that he wondered "whether there was really any learning from this activity."[591]

278. The Inquiry is deeply concerned that the approach adopted by the Trust with regards to this aspect of the determination. The recommendation that there should be an independent review of the relevant system-wide problems to understand and learn from the findings was a sensible, well-focused and urgently needed outcome from the MHPS process. The reason put forward to explain the delay in establishing and progressing the review – namely, that a Grievance first required to be addressed - is, in the Inquiry's view, a spurious one and does not withstand close scrutiny. The focus of the review was to be on the behaviours of management and the processes which they used. It should have been conducted urgently, regardless of the issues which fell to be addressed within the Grievance.

587 TRA-04062, lines 22-26
588 TRU-265527 to TRU-265528
589 WIT-32073
590 WIT-32141 to WIT-32143
591 TRA-04068, lines 4-6

The delay in its commencement deprived the review of any practical benefit. The scope of the review, limited as it was to actions taken within the urology service, was not what Dr Khan had intended; this rendered it unfit for purpose. Moreover, the Trust's failure to appoint external reviewers, as expressly recommended by Dr Khan, deprived the review of the independence which had been considered necessary.

279. If there is one criticism which could be directed to Dr Khan in respect of his findings, it is that they did not go far enough. This Inquiry has noted that the Medical Director's Office was, or ought to have been, sighted on the difficulties posed by Mr O'Brien's conduct for many years. This was not just a failure of management and governance within the Acute Directorate; it was a failure which went all the way up to the Medical Director's Office.

Return to Work plan and monitoring arrangements

280. It had been envisaged that Dr Khan would have an active role in overseeing the Return to Work Plan and monitoring arrangements in that any deviations were to be reported to him, and he was to receive assurance reports.[592] Dr Khan explained that, if any concerns emerged in relation to Mr O'Brien's practice, these could be fed into the Oversight Committee which would have the option to consider exclusion.[593] However, throughout the MHPS investigation period, Dr Khan was not made aware of any issue or concern which would have merited further consideration by the Oversight Committee. He was advised of some deviations from the Plan, but he considered that these were dealt with promptly, managed and rectified.[594] Dr Khan explained that, in or about May 2017, a concern was identified that Mr O'Brien may have been in breach of the Plan by continuing to retain or store significant numbers of patient notes in his office. Dr Khan was advised of this and, after local management met with Mr O'Brien to discuss the issue, Dr Khan was provided with assurance that the issue had been

592 WIT-31985, paragraph 12.6
593 TRA-03906, lines 17-28
594 WIT-31988, paragraph 14.1; TRA-03906, line 29 to TRA-03907, line 19

satisfactorily addressed.[595] The Inquiry acknowledges that episode represents a period of good practice on the part of those managers who were responsible for challenging any apparent departure from the requirements of the plan.

281. However, the Inquiry did receive troubling evidence of occasional failures on the part of staff within the Acute Directorate to adequately monitor Mr O'Brien's compliance with the Plan, and some failures to inform Dr Khan of episodes of non-compliance. In February 2018, a concern arose within the Acute Directorate that Mr O'Brien had failed to triage a red flag referral in a timely fashion.[596] This was not reported to Dr Khan, and indeed there had been a failure to issue monitoring reports to him for some months before this specific issue arose; his attention was only drawn to the issue because Ms Toal had become aware of it and advised him that there had been a problem.[597] Plainly, this is an example of poor practice on the part of those with responsibilities to oversee compliance with the Plan and to report deviation from it. The Inquiry did not receive an adequate explanation as to why Dr Khan was not receiving monitoring reports; why he did not seek them out when they were not provided; why he did not take the opportunity to emphasise the importance of being kept informed; and why, in the event of an apparent deviation from Mr O'Brien's triage obligations, Dr Khan was not advised.

282. The failure to address these gaps made it more likely that problems would recur, and they did recur later in 2018. In her role as HOS for Urology, Ms Corrigan was allocated the lead responsibility for the monitoring arrangements and reporting any deviation from the Plan. However, she was absent from work for an 18-week period between June and November 2018.[598] This was not known to Dr Khan. In her absence the responsibility for the monitoring arrangements was not allocated to anyone else, with the effect that no monitoring took place. In his evidence, Dr Khan explained that he only became aware of a failure of compliance in

595 TRA-03993 to TRA-03994
596 TRU-264481
597 TRA-03996, lines 5-9
598 WIT-39914, paragraph 18.2

October 2018.[599] At that time Mr Weir advised that it had been discovered that Mr O'Brien had a significant backlog of dictation, with 91 clinic letters not dictated (the earliest dating back to 15 June 2018) and that there were 82 patient charts being held in his office.[600] Despite characterising this as a "significant deviation" of a type which he believed could have led to "major issues with the patient care", Dr Khan did not meet with Mr O'Brien to discuss the deviation.[601] Rather, he simply wrote to Mr O'Brien to ask whether he was adherent to the action plan.[602] As Case Manager, Dr Khan ought to have met with Mr O'Brien to discuss his deviation from the Plan and express his concerns. Given his reported strength of concern, it is difficult to understand why he did not do so. The Inquiry considers that the failure of monitoring and the absence of any formal engagement with Mr O'Brien to express the Trust's dissatisfaction with his performance, represents a failure of management.

283. In his case determination, Dr Khan recommended that the Return-to-Work arrangements should be reviewed and updated. He explained to the Inquiry that he had reached the view that the monitoring process "was not as robust as it should have been," because it was over-reliant on one or two people and there was an absence of any monitoring by clinical managers.[603] We agree that the failure to involve clinical managers in the monitoring arrangements was a significant weakness. Despite Dr Khan's recommendation, the Trust failed to implement a new plan and the frailties of the original arrangements were not addressed. Several witnesses told the Inquiry that this was because Mr O'Brien had initiated a Grievance process, which blocked the progress of Dr Khan's recommendations.[604] This explanation is a poor one. The fact that Mr O'Brien may have challenged the outcome of the MHPS process should not have

599 TRA-03999, lines 17-22
600 TRU-251526 to TRU-251528. The failure to dictate on clinics was initially documented as involving 91 cases, although it was later observed that this had reduced to 16 cases by 23 October 2018
601 TRA-04006, lines 17-18 and lines 28-29
602 TRU-261997
603 TRA-03961, line 26 to TRA-03962, line 13
604 TRA-04012, lines 12-25; WIT-21133

prevented the Trust from taking the steps suggested by Dr Khan, including engagement with PPA, to draw up a revised plan.

284. Indeed, a degree of uncertainty arose regarding the continued applicability of the Plan and monitoring arrangements. In October 2018, Mr Carroll wrote to Dr Khan enquiring as to whether the monitoring was to continue. Dr Khan confirmed that it was and emphasised that the action plan "must be closely monitored".[605] In evidence, Dr Khan expressed his surprise that there should have been any uncertainty about this and was clear that it should remain in place.[606]

285. A further difficulty emerged in September 2019, when Ms Corrigan reported to Dr Khan that multiple referrals had not been triaged by Mr O'Brien and a number of clinics through August and early September had not been dictated by him. Dr Khan had issued his MHPS determination 12 months previously and his duties as interim Medical Director ended in December 2018. It appears to the Inquiry that this should have signalled the conclusion of his involvement in matters pertaining to Mr O'Brien. When he spoke to the Inquiry he expressed, understandably, a degree of puzzlement about the reasons for his continued involvement, although he does not appear to have actively questioned Dr O'Kane about this.[607] It was decided that Ms Corrigan and Mr McNaboe should meet with Mr O'Brien to discuss these issues. In response to the request for a meeting, Mr O'Brien indicated that he considered that the Return to Work Plan had expired in September 2018 when the MHPS Determination had issued.[608] He accurately referred to the text of the Plan, which stated that it would be effective:

> "pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework."[609]

605 TRU-251531 to TRU-251532
606 TRA-04003, lines 17-25; TRA-04014, lines 1-19
607 TRA-04009, lines 10-29, TRA-04010, line 11; TRU-275324 to TRU-275331; TRU-275344
608 TRU-275595
609 TRU-275595

He highlighted the fact that, although the MHPS Determination had recommended the formulation of a new action plan, the Trust had failed to implement this recommendation.

286. The points raised by Mr O'Brien have substance even if the circumstances giving rise to his correspondence, namely his failure to comply with his obligations around triage and dictation, do not reflect favourably upon him. Mr O'Brien had been told that the action plan would remain in place for the duration of the MHPS process; he was entitled to assume that the plan was no longer in operation, and that a new one would be developed by the Trust in line with the determination. We do not accept Dr Khan's suggestion that his correspondence with Mr O'Brien on 23 October 2018, ought to have signalled to him that the Plan remained in operation. Inexplicably, it appears that no one, neither Dr Khan nor the Oversight Committee, considered it necessary to formally communicate to Mr O'Brien the Trust's view that the plan would remain in place pending the development of a new one. Notwithstanding an MHPS process which highlighted shortcomings in the management of Mr O'Brien over many years, the Trust was no closer to addressing those shortcomings. By the end of 2019, Trust management had relinquished any semblance of control in how performance issues surrounding Mr O'Brien's practice had been managed. A new action plan and monitoring arrangement was never developed. The planned formal discussion between Mr McNaboe and Mr O'Brien did not take place; it was relegated to a brief informal chat in the corridor.[610]

287. On 21 January 2020, prompted by the September 2019 concerns, a meeting took place to discuss the issue of dictation following clinics.[611] Bewilderingly, that meeting reached the view that the absence of written standards in relation to the dictation of clinics, and the absence of agreed procedures for escalating concerns, meant that there were likely to be "challenges in taking forward this issue with Mr O'Brien."[612] The meeting also noted the reliability or accuracy of

610 WIT-15750, paragraph 55.4
611 TRU-251814
612 TRU-251815

backlog reports in this context may be open to question, a point which Mr Haynes had been highlighting for some time.[613]

288. It appears to the Inquiry remarkable that the Trust should have handled the implementation and supervision of the monitoring arrangements with what can only be described as casual indifference at times. Mr O'Brien was a doctor whose performance had merited an extensive MHPS investigation which exposed obvious problems with his performance, some of which involved a risk to patient safety. The Trust considered that it could only tolerate his return to work following a period of exclusion if aspects of his work were the subject of specific and well-defined standards with which he was required to comply, and a monitoring arrangement was put in place to ensure that he did so. Yet, the evidence before the Inquiry demonstrates that Mr O'Brien's performance was not always monitored; deviations were not always reported to the Case Manager, and never escalated beyond him, even if the Medical Directors (both Dr Khan and Dr O'Kane) were aware; there was no evidence of formal criticism or expression of concern directed to Mr O'Brien; there was confusion after the completion of the MHPS process surrounding the continued applicability of the plan, which was never adequately resolved; and ultimately the Trust resolved that a key component of the plan regarding the requirement to dictate an outcome following a clinic, was not enforceable.

289. While the Inquiry accepts that Mr O'Brien's performance was usually compliant with the requirements of the plan, it was not always so, and the Trust's ability or preparedness to meet this with an appropriately rigorous response fell far short of what was clearly necessary. In our view, this can largely be attributed to the monitoring plan not having been appropriately shared and owned by relevant medical managers. Indeed, it appears that they effectively did not know what was happening nor who was in charge. It was left to Ms Corrigan to undertake the monitoring and to report breaches in relation to certain administration issues, but

613 TRU-251814

there was no medical manager in the Acute Directorate who had full sight of this.[614] Mr Haynes in an email to Ronan Caroll dated 18 October 2018 stated:

> "According to Simon '… there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties…'
> I wasn't one of these interested parties, neither from Colin's email was he, or Michael from his. So if the CL in the service, the CD and the AMD weren't, I'm not sure who was.
> I can only assume, given the trusts previous failings in tackling behaviours in this case, the arrangements were robust, regularly monitored at multiple levels and had clear backstops for sickness etc so that it wasn't reliant upon only Martina??"[615]

290. Medical management should have been involved. This was a clear failing. Moreover, the monitoring arrangements were not properly thought through and were excessively labour-intensive. They were also potentially unfair to Mr O'Brien. The other consultants were not set a standard to work to that was monitored in this way, and data collection systems were not completely robust. The data collected should have applied to the entire Urology Department.

291. Mr O'Brien should have been offered a programme of support and met regularly with a medical manager to see how he was coping and what issues were arising. Mr O'Brien made a number of statements about taking regular annual leave to catch up on his administration tasks, allegedly with the knowledge of his team and medical managers, but it is unclear how this was viewed.[616] There was, in effect, no personal programme of support for Mr O'Brien so that he could change his practices. Exclusion of a doctor should always be done as a last resort and doctors should, wherever possible, return to work with the support required to change any practice which is considered to be harmful.

614 WIT-26315, paragraph 70.6
615 TRU-258911
616 TRU-272986; TRU-273744; TRU-274773; TRU-00033; TRU-275085 to TRU-275086; AOB-01823; TRA-04692, lines 1-6; TRA-06999

The role of the Designated Board Member and Trust Board

292. The role of the Designated Board Member in MHPS investigations was considered in a number of inquiries into MHPS and also by the Kennedy Review,[617] which concluded that:

> "On the face of it, this appears to be a mechanism whereby the Board, and more particularly, the Non-Executive members, have a link with and are kept appraised of developments in the investigation. As such, it looks like a sensible mechanism of assurance for the Board."[618]

However, in that Trust:

> "there was no protocol, nor guidance for the designated Non-Executive to follow in carrying out this role. No one, for example, briefed Ms East [the Designated Board Member] when she took on the role that there had been a previous investigation" and the role was, therefore, reduced to "some form of window-dressing" and "provided no assurance to the Board about the conduct of an investigation."[619]

We consider there to be a number of parallels between these findings and the role of the Designated Board Member in the investigation concerning Mr O'Brien.

293. In the formal investigation concerning Mr O'Brien, Mr Wilkinson, a retired schoolteacher and educational consultant who had been on the Board since February 2016, was appointed as the Designated Board Member on 19 January 2017.[620] He was appointed by Mrs Roberta Brownlee, Chair of the Trust Board. The MHPS Framework and the 2010 Guidelines describe the role of the Designated Board Member as being:

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617 INQ-30060 to INQ-30225, Kennedy Review (Review of the Response of Heart of England NHS Foundation Trust to Concerns about Mr Ian Paterson's Surgical Practice 2013)
618 INQ-30119, paragraph 7.18
619 INQ-30119, paragraphs 7.19, 7.21 and 7.22
620 WIT-26106

> "to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation."[621]

The 2010 Guidelines further explain that it is the role of the Designated Board Member to:

> "ensure that the investigation is completed in a fair and transparent way, in line with Trust Procedures and the MHPS Framework. The Non Executive Board member reports back findings to Trust Board."[622]

294. Mr Wilkinson described to the Inquiry that he received "broad general training" on the MHPS Framework from Departmental Legal Services (DLS).[623] The session length was described in an email as expected to last "no more than an hour".[624] He explained that, at the training he received in September 2016, the role of the Designated Board Member was:

> "unclear and was highlighted as such by the trainer who on several occasions stated that the role was indistinct and that the Department of Health had been asked on several occasions for clarification but none had been provided."[625]

Mr Wilkinson further described how:

> "The inter-relationships and expectations surrounding the Case Manager, Case Investigator, HR, Medical Director, Trust Board, and Chief Executive were not explained sufficiently."[626]

621 TRU-292411 to TRU-292412, Section I, paragraph 8; TRU-83690, paragraph 2.10.
622 TRU-83702
623 WIT-26106 to WIT-26107; TRU-164777; TRU-164714 to TRU-164751
624 TRU-164777 to TRU-164778
625 WIT-26106 to WIT-26107, paragraph 64
626 WIT-26116, paragraph 94

and explained that, because of the complexities of the process and the intricacies of the specific case, he found himself "bewildered, if not compromised, from time to time."[627] Nevertheless, and despite the fact that the trainer had expressed concern about the clarity of the role, it appears that Mr Wilkinson did his best to execute the role in a reasonable manner and had understood its basic elements. The ill-defined nature of the Designated Board Member's role was also recognised by Ms Toal, who described it as "particularly difficult … to comprehend".[628] It is difficult to see how the Designated Board Member could add value in such circumstances. Nevertheless, Mr Wilkinson explained that he saw his role as being to:

> "liaise with Mr Aidan O'Brien ('AOB') and ensure the momentum of the Maintaining High Professional Standards ('MHPS') process in respect of AOB was maintained by ensuring timely responses to requests made by AOB."[629]

295. On 07 February 2017, Mr Wilkinson and Mr O'Brien had, what Mr Wilkinson described as, a "difficult meeting", in which Mr O'Brien outlined the various workload pressures he was under and indicated that:

> "if he was to be found wanting in his practice then he would bring a degree of embarrassment to the SHSCT."[630]

In advance of the meeting, Mr O'Brien prepared a summary of concerns relating to the investigation up to that point, centring on the March 2016 letter, the relationship of the Patient 10 SAI to the decision to formally investigate, and issues with the conduct of the formal investigation itself.[631] Mr Wilkinson wrote to Mr O'Brien on 13 February 2017 to state that his submissions and the notes of the meeting had been shared with the Oversight Committee and that Mr Wilkinson would "properly consider" same and "discuss fully with the relevant

627 WIT-26117, paragraph 97
628 WIT-41144, paragraph 27(v)
629 WIT-26092, paragraph 2
630 WIT-26093, paragraph 9
631 TRU-01248 to TRU-01251

individuals involved" before reverting to Mr O'Brien.[632] After the Trust had obtained legal advice, a response to the submissions issued from the Case Manager on 24 February 2017.[633] Following a phone call from the Board Chair, Mrs Brownlee[634] to Mr Wilkinson,[635] contact between Mr Wilkinson and Mr O'Brien was reinitiated on 06 March 2017 by telephone and, in a subsequent email, Mr O'Brien indicated that he was:

> "entirely taken aback and disappointed that a response should come from the Case Manager.
> That it did implied to me that your role on my behalf does not enjoy autonomy."[636] (emphasis added).

Mr O'Brien then attached a further list of 47 questions which required a response.[637] In response, Mr Wilkinson provided an update on the investigation to Mr O'Brien, indicating that he could expect to be interviewed in mid-late April and that his questions had been passed to HR and "will be addressed by appropriate persons."[638]

296. Mr Wilkinson told the Inquiry that, at this stage, he:

> "had concerns that he [Mr O'Brien] misunderstood what my role of NED entailed. My role under the MHPS framework and Trust Guidelines of 2010 was to ensure that the momentum of the case was maintained, to consider representations made by AOB [Mr O'Brien], and to report the MHPS findings to the Board in due course. I did not feel that I was equipped to carry out the level of inquiry requested by AOB. Further I did not perceive myself to be an advocate, a representative, supporter, mediator or inquirer [sic] I advised AOB that if he needed aspects of the Inquiry clarified that he should address his

632 TRU-158265 to TRU-158266
633 TRU-261904 to TRU-261910
634 More is said about Mrs Brownlee's actions in the Governance chapter
635 WIT-26095 to WIT-26096
636 TRU-261911 to TRU-261919
637 TRU-261920 to TRU-261924
638 TRU-261925

queries and concerns to the Case Investigator or Case Manager directly. I advised him that he should contact me if he felt that matters were moving slowly or if he felt he was being obstructed in any way."[639]

297. Given his relative lack of training and experience, and the disconnect between the handling of the concerns regarding Mr O'Brien and Mr Wilkinson's role as a Non-Executive Director (NED), it is difficult to see how Mr Wilkinson would have been best placed to consider and respond to any representations regarding the investigation. Initially, Mr Wilkinson received updates from Ms Toal and, thereafter, predominantly from Ms Hynds. Occasionally, he received updates from Dr Khan.[640] Dr Khan considered that there was no element of "challenging" in the way that Mr Wilkinson approached his role; rather, it was:

"more about keeping up-to-date and also to encourage, [us] to move along and finish the investigations."[641]

298. The 2010 Guidelines express the expectation that the Designated Board Member "reports back findings to Trust Board."[642] Dr Khan suggested that the escalation of any concerns to the Trust Board was the "biggest weapon" at the Designated Board Member's disposal, in the event they were unhappy with the progress of an investigation. [643] The Inquiry has seen no evidence to suggest that Mr Wilkinson did formally report to the Trust Board on the progress or findings of the investigation, either during the currency of the MHPS investigation, or subsequently. We consider this to have been a missed opportunity. The Kennedy Review considered such failure to formally report a "serious failure" and while noting that "There may have been informal exchanges," these:

"cannot serve as a substitute for formal reporting. Without such reporting, the organisation, as an organisation, has no knowledge or memory of events.

639 WIT-26097, paragraph 23
640 WIT-31976, paragraph 7.6(a)
641 TRA-03918, lines 17-25
642 TRU-83702
643 TRA-03919, lines 19-26

It is an elementary rule of good governance that matters of such importance that they are judged to warrant both formal internal and external investigations must not be left to the vagaries of recollections of individuals, which, of course, may differ over time."[644]

This Inquiry agrees.

299. The Inquiry is aware of only one record of the Trust Board having been briefed on the concerns regarding Mr O'Brien during the MHPS investigation. The minutes of a confidential board meeting held on 27 January 2017 record that Ms Toal and Dr Wright provided an update on the situation with regards to Mr O'Brien as follows:

"Mrs Toal advised that under the MHPS framework, there is a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one Consultant Urologist was immediately excluded from practice from 30th December 2016 for a four-week period. Mrs Toal reported that the immediate exclusion has now been lifted and the Consultant is now able to return to work with a number of controls in place.

Dr Wright explained the investigation process. He stated that Dr Khan has been appointed as the Case Manager and Mr C Weir, as Case Investigator. Mr J Wilkinson is the nominated Non Executive Director. Dr Wright confirmed that an Early Alert had been forwarded to the Department and the GMC and NCAS have also been advised."[645]

300. Aside from its brevity, and lack of follow-up, the Inquiry has a number of concerns about this briefing. Firstly, whilst Mrs Brownlee is recorded as leaving the room, there is no evidence that she declared a formal conflict of interest, despite this

644 INQ-30119 to INQ-30120, paragraphs 7.23 and 7.24
645 TRU-158979 to TRU-158981, paragraph 6; TRU-00076 to TRU-00078; TRU-00087 to TRU-00088; DOH-71988 to DOH-71993

being known to both Dr Wright and Ms Toal, neither of whom appear to have raised it. It was her obligation to make a formal declaration of that conflict. The role of Mrs Brownlee is explored further in the Governance chapter. Secondly, the update is not entirely accurate. No Early Alert had been sent to the Department at that time. Rather, the Medical Director notified the Chief Medical Officer by letter on 30 December 2016 of the immediate exclusion, in accordance with the MHPS Framework, he then suggested that there were grounds for an Early Alert.[646] Further, while it appears that there was some discussion with GMC at the time, there was no formal referral to it.

301. The Inquiry has not seen any further documentation which records that a formal briefing was provided to the Trust Board by the Medical Director, HR Director, Acute Services Director or Designated Board Member, Mr Wilkinson. It is most concerning that, what appears to have been the sole briefing to the Trust Board in relation to this investigation, contained inaccuracies. In the absence of any formal audit mechanism in relation to MHPS investigations in the Trust, oversight by the Trust Board becomes an even more significant function. In the circumstances, it is clear that the Trust Board could not have received adequate assurance when senior management did not update the Board regarding MHPS investigations.

Conclusions/Findings

302. Prior to Dr Wright's appointment as Medical Director in 2015, there was a distinct reluctance on the part of medical managers to address the issues with Mr O'Brien. While the Inquiry is of the view that Dr Wright did not handle the situation with Mr O'Brien optimally, he was the first Medical Director to try to address the issues regarding Mr O'Brien when they were drawn to his attention. It is clear that as a new Medical Director having many other issues to manage, he took the matter seriously. He gave appropriate direction to Mr Mackle and Ms Trouton and by the end of the year, when matters came to a head, he set up an Oversight Committee and initiated formal MHPS proceedings. He deserves

646 TRU-161678; TRU-161682 to TRU-161684; TRU-161698; TRU-161699 to TRU-161702

credit for taking action when others had failed to. We consider that, had the medical managers been prepared to take action to address the issues with Mr O'Brien's practice, things could have improved sooner.

303. In our view, there were a number of reasons for this reluctance. Mr O'Brien was the founding consultant of the urology unit in 1992 and remained its senior figure until he submitted his request to retire from practice and left Trust employment in 2020. His long tenure and foundational role gave him significant influence. There is ample evidence before the Inquiry which demonstrates Mr O'Brien being a "challenge to challenge", as he was described by Mr Haynes.[647] The Inquiry has noted Mr O'Brien's response to challenges or changes that he disagreed with.[648] When confronted, he often pushed back strongly as illustrated by his response, for example, to the antibiotic issue, to the request to follow a pragmatic approach to triage and when asked to ensure that results were looked at. This is described further in the Clinical Aspects chapter. The Inquiry formed an impression that this had the effect of wearing people down, thus providing resistance to effective change. Dr O'Kane noted that Mr O'Brien's colleagues had "developed ways of not confronting him for fear of having to deal with unpleasantness".[649]

304. Moreover, it was common knowledge within the Trust that Mr O'Brien was a very close friend of the Chair of the Trust Board, Mrs Brownlee, and that members of his family were in the legal profession; this knowledge appears to have had a chilling effect on those who were tasked with managing him.[650] These issues are discussed in greater detail in the Governance chapter.

305. It was not until Dr Wright became the Medical Director, at the same time as there was a change in the Director of Acute Services, that the opportunity was seized to try to do something about the concerns regarding Mr O'Brien's practice.

647 TRA-00842, lines 1-2
648 TRA-06354 to TRA-06356; TRA-02167; TRU-276804 to TRU-276807; TRA-02151; TRU-278868 to TRU-278870; WIT-26223 to WIT-26224; WIT-27883 to WIT-27887; WIT-26295
649 TRA-01481, lines 11-15
650 TRU-00773, paragraph 18; TRA-00842 to TRA-00844; WIT-11748, paragraph 39; WIT-26095 to WIT-26096, paragraph 19; WIT-26224, paragraph 30.12; WIT-26300 to WIT-26301, paragraph 67.5; WIT-45034, paragraph 30.4

Mr Mackle spoke with Dr Wright, who directed that the concerns be committed to writing and delivered to Mr O'Brien in a meeting. This was the first time that the concerns had been reduced to writing in this way. Ultimately this led to the MHPS investigation several months later.

306. The MHPS investigation concerning Mr O'Brien set out to look at five issues. These issues did not require much in the way of investigation; they were already clear, obvious and in the open. It was abundantly clear that Mr O'Brien did not follow the Trust's 'rules' on triage, dictation and the retention of patient notes. The concerns about his approach to managing private patients within the HSC, had already been expressed.

307. The work of the investigation was complete by Autumn 2018. Less than two years later, the Trust was faced with a major scandal; it was concerned to discover that there were additional, potentially much more serious concerns associated with the clinical practice of Mr O'Brien which had caused harm to patients, or which placed them at risk of harm. These issues had not been discovered as part of the MHPS investigation, nor had they been looked for. As Dr Chada explained, the rules of the process did not permit her to engage in a 'fishing expedition'. Moreover, she was reassured by colleagues that there were no clinical concerns in relation to Mr O'Brien.[651]

308. The public should be deeply concerned, as are we, that the Trust, acutely aware of a series of significant shortcomings in the practices of one of its most senior clinicians, should spend two years examining what was already known, and not seek to examine more closely *how* Mr O'Brien operated his practice. This absence of basic curiosity, equally demonstrated by doctors and the Trust Board, caused the scope of the investigation to be narrow and limited and must be regarded as a failure of good governance.

651 TRA-03626, line 19 to TRA-03627, line 19

309. Significant elements of a clinician's practice take place behind closed doors or may not give rise to any suspicions unless probed. An organisation cannot know whether there is a problem if it does not look. The basic problem was that there were no regular audits of compliance with clinical guidelines in the Urology Department, nor were there relevant national audits. As a result, there was no data in regular use in relation to the quality of clinical intervention or in relation to any administrative procedures. The Trust could have performed an audit of specific categories for all consultant urologists (such as compliance with guidelines, numbers of patients seen in clinic, or time taken to respond to letters). This would have allowed the Trust to ascertain the extent to which the concerns identified in respect of Mr O'Brien's practice were replicated across the specialty or, if they were not, to identify aspects of his practice which perhaps merited further examination. The issue of audits is considered in greater detail in the Clinical Aspects chapter.

310. In any event, at the conclusion of the MHPS investigation, the case for a wider probe was almost unanswerable. It does appear that senior managers within the Trust now recognise that the organisation was naïve when it failed to take a closer look in 2017.[652]

311. We have explained that an investigation of the management of Mr O'Brien's performance ought not to have been included within this MHPS investigation. The failures to properly manage Mr O'Brien, and the failure of the governance arrangements to draw adequate attention to his performance shortcomings, were clearly matters which required a separate careful and considered investigation, as implied by Dr Khan's case determination.

312. Whilst it is clear that some individuals in management roles were aware of these issues, it is not clear that they were escalated to those in senior management positions. In her report, Dr Chada concluded:

652 TRA-06938 to TRA-06941; WIT-26314 to WIT-26315, paragraph 70.6

> "Senior managers appear not to have known about the undictated letters. Reliance on a medical secretary to flag that dictation was not being done was not appropriate or sufficient. This is now hopefully addressed through use of digital dictation.
>
> Senior managers also appear not to have known that private patients may have been scheduled with greater priority or sooner outside their own clinical priority in 2015 and 2016."[653]

The Inquiry has seen evidence that senior managers were aware, and Dr Chada's conclusion is therefore incorrect, although we accept it was based on evidence provided to her at that time.

313. An example of a failure to appropriately escalate an issue can be seen in relation to the private patients concern. On two occasions in 2015, Mr Haynes wrote to Mr Young and Ms Corrigan to express his concern that private patients were being unfairly prioritised by Mr O'Brien and asked Mr Young, as CL, to do something about it.[654] Mr Haynes explained that he had taken these steps in an effort to inform senior management.[655] It is our view that nothing substantive was done to address Mr Haynes' concerns. Mr Young claimed to have raised the issue with Mr O'Brien on one occasion, but we entertain significant doubts about this.[656] Mr O'Brien denied that the issue was ever raised with him before the MHPS investigation commenced and there is no record of Mr Young having taken any action.[657] We consider this to have been an example of a member of management burying his head when informed of a significant concern. This was a failure of medical leadership.

314. The investigation of the private patient issue was wrapped in confusion and lacked transparency. Despite having interviewed Mr Young earlier in her

653 TRU-00703
654 WIT-54107; WIT-54106
655 TRU-00787, paragraph 26
656 TRU-270116
657 TRA-04742 to TRA-04743

investigation, Dr Chada was unaware that a parallel investigation was being conducted by Mr Young until his findings were produced in August 2017.[658] Whilst Mr Young's report lacked precision and breadth, it nonetheless confirmed that there was an issue. Nevertheless, when his report was delivered, Dr Chada did not speak to him about it and did not take the opportunity to probe his methodology or the conclusions which he had reached.[659] In the circumstances, the Inquiry has formed the impression that the private patient issue was investigated in a manner which lacked rigour; no attention was paid to the Trust's procedures for transferring patients from the private setting to the NHS and whether there was compliance.

315. Mr Young's report analysing the 11 private patient cases could have been done better. However, it was clear that Mr O'Brien did not follow the Trust's procedures and added private patients to the waiting list when he saw fit, often when he had been contacted directly by them. Mr O'Brien may not have set out to advantage private patients but, in practice, the fact that his private patients had greater access to him to explain their problems ultimately meant that they were advantaged when compared with HSC patients. Their treatment was effectively accelerated.

316. Dr Chada found that Mr O'Brien did not appreciate the gravity of the concerns which she investigated, highlighting that he "displayed some lack of reflection and insight into the potential seriousness" of these issues.[660] She further noted that he dismissed the importance of administrative processes, that he "does his own thing" by substituting extra theatre lists for his administrative duties, and could not do triage in the way that was expected of him, but disagreed with it anyway.[661] She drew particular attention to what she described as his "disappointing" response to the plight of the cancer patients who experienced delayed diagnosis because of his decision not to triage their referrals.[662]

658 TRU-01069; TRA-03676 to TRA-03683
659 TRA-03678, lines 10-14
660 TRU-00705
661 TRU-00705
662 TRU-00705

317. The Inquiry received a great deal of evidence both from and relating to Mr O'Brien. Moreover, we had the benefit of hearing from him in person over several days and it was clear to us that Mr O'Brien chose to focus and prioritise those things that he felt were important while ignoring the risk to patient safety in other areas. The Trust tolerated this and thereby did patients a disservice but equally were unfair to a competent clinician in failing to remediate his behaviour and allowing him to end his career in this fashion. As discussed further in the Medical Management and Leadership chapter, the Trust has recognised the need to improve the management of doctors in difficulty. It has taken steps to provide training and development of medical managers so that doctors can be supported to improve their practice when needed.

318. From the commencement of the MHPS investigation Mr O'Brien recorded meetings without informing others, including colleagues and management, without seeking their consent. He admitted to the Inquiry that he did so and provided us with the tapes themselves and transcripts thereof. He did not provide a single explicit rationale for recording the meetings but gave various reasons for doing so, including having done so at the request of his wife who has a hearing impairment. He was dishonest when asked directly by Ms Shirley Young at the Grievance hearing whether he was recording.[663] While it might have served him well in having a record to either protect himself or provide clarity in a complex and adversarial environment, Mr O'Brien showed a complete disrespect towards colleagues and management by covertly recording meetings. He told us he appreciated the sense of intrusion and violation felt by his colleagues but that having a reliable record justified him acting in the way he did. The Inquiry disagrees. It is one thing to record meetings (or telephone calls) in order to ensure that there is an accurate record of what is said, it is quite another to do so covertly. The sense of violation and upset caused was evident when some of those affected spoke to the Inquiry.[664] This action is indicative of the extent of

663 See TRA-04820 to TRA-04829 where Mr O'Brien is questioned about covert recordings by Inquiry Counsel; AOB-56500 to AOB-56502; TRA-04826 to TRA-04829

664 TRA-01294 to TRA-01295; TRA-02714; TRA-03046 to TRA-03047; TRA-03772 to TRA-03775

Mr O'Brien's distrust of those he saw as either acting or potentially acting contrary to what he perceived as his interests.

319. In summary, the Trust failed to deal with longstanding issues regarding Mr O'Brien's practice in a timely and effective matter for several years. We have concluded that there was no appetite amongst the medical management cadre to address the issues. It is our firm view that the MHPS Framework could have been invoked at a much earlier stage. However, due to reluctance and a lack of knowledge relating to the process itself, it was not.

320. In conclusion, having regard to paragraphs (a) and (e) of its ToR, the Inquiry has carefully examined the Trust's approach to addressing issues of concern relating to Aidan O'Brien prior to 2020, including its implementation and operation of the *Maintaining High Professional Standards* (MHPS) Framework in investigating Mr O'Brien's practice. The Inquiry has identified the following shortcomings:

    i. Concerns about various aspects of Mr O'Brien's practice, which should have given rise to concerns for patient safety, had been known about for many years. These issues were not addressed effectively by management within the Trust, particularly those in the medical management line. The managerial response was characterised by delay, inconsistency, an absence of escalation, a tolerance of non-compliance and the adoption of 'workarounds' which enshrined poor performance and jeopardised patient safety. Overall, prior to 2016, the Trust failed to avail of the processes which were available to identify, challenge and correct poor standards of professional practice.

    ii. When, eventually, the Trust pressed Mr O'Brien to address the need for improvement in March 2016, it failed to provide clarity, support or measurable objectives. There was also insufficient input from HR and an absence of prompt follow-up by Trust management.

iii. Having failed to achieve meaningful improvement with this intervention in March 2016, the Trust's decision to deploy the MHPS framework was undermined by delay, confusion and a lack of leadership.

iv. Aspects of the decision to move to a formal MHPS investigation lacked transparency and there was a failure to comply with key procedural requirements. The Inquiry considers, however, that the Trust was correct to move to a formal investigation.

v. While the MHPS investigation was generally thorough having regard to the terms of reference set for it, the process was excessively delayed.

vi. The conclusions reached by the Case Manager were coherent and sensible and offered an opportunity to make meaningful improvements, however there was a failure to take action to implement his recommendations and a failure to refer Mr O'Brien to the GMC in a timely manner. In essence, a process which was undertaken over a period of two years, and which required the deployment of significant resources, did not result in meaningful action at its conclusion.

vii. The MHPS investigation identified significant shortcomings in the performance of Mr O'Brien in important areas of his work. This should have prompted scrutiny of other areas of his work. There was a complete lack of curiosity so that this scrutiny was not carried out, with the consequence that significant additional patient safety issues connected with Mr O'Brien's practice were not identified, and therefore remained unaddressed, for a further two years. It is the firm conclusion of this Inquiry that his professional behaviours merited an extensive investigation by the Trust long before the Summer of 2020.

viii. Mr O'Brien was an experienced clinician and ought to have recognised that his standards of professional practice were deficient in key respects even if, as the Inquiry recognises, he was working in a challenging and under-

resourced environment. His refusal to adapt his working methods and to cooperate with colleagues and management placed the safety of patients at risk.

ix. Overall, the Inquiry has been concerned with the number of hurdles which the MHPS framework places in the path of a Health and Social Care (HSC) employer, such as the Trust. The Inquiry has significant reservations regarding the general efficacy of the framework and doubts whether a standalone framework such as MHPS serves the interests of all concerned but, in particular, patients. Equally, the process as it stands was not well-utilised by the Trust and many of the problems which were encountered could be said to be self-inflicted.

x. The Inquiry notes that the Department has recently examined the case for departing from the MHPS framework. In the Recommendations section of this chapter we encourage the Department, in light of this Inquiry's findings, to assess whether it is now time to address performance and conduct issues affecting medical staff in the same manner that such issues would be addressed with other members of the workforce.

Changing the MHPS Framework and Recommendations

321. In an adequately supported healthcare system, important policies, such as the MHPS Framework, would be the subject of regular review. The Inquiry accepts that this framework is one which involves a large number of stakeholders and that proposed revisions or reforms are difficult. We note that the Department accepted the need to co-ordinate a review of the framework following the INI and has made significant progress in setting out areas where reform is required.

322. The MHPS Framework has not been amended since its introduction in 2005. This is despite both significant regulatory reforms which have been made to the HSC system in the period that has followed (most notably through the introduction of the role of the Responsible Officer (RO) and the process of Revalidation, in 2010

and 2012 respectively) and the relevant recommendations emerging from the INI in relation to the Framework.

323. In his evidence to the Inquiry, Mr May, then Permanent Secretary to the Department, explained that, since its introduction, the Department has led two separate attempts to review the MHPS Framework. However, both of these reviews "were unfinished and therefore unimplemented" and, as such, "no action has been taken by the Department in regard to amending MHPS."[665]

324. The first attempt to review the MHPS Framework took place between 2011 and 2013. It was seemingly prompted by the fact that the equivalent policy had been updated in England whereas, in Northern Ireland, employers continued to struggle with an MHPS process which was 'clunky', slow and difficult to navigate.[666] A MHPS Working Group was established and, over a period of two years, views were obtained from a variety of stakeholders including the HSC Trusts, NCAS, and the Labour Relations Agency. A rich and detailed account of the main difficulties which were experienced when operating the MHPS Framework was assembled following these engagements and this presented a real opportunity to bring forward an improved policy.[667] Despite this, the policy was not updated.

325. The second piece of work, initiated in 2018, was less comprehensive by comparison with the earlier effort. Correspondence was received by the Department from the Belfast Trust in early 2018, wherein it was stated that the "practical application" of MHPS was becoming increasingly difficult.[668] This prompted the Department to call on the other Trusts to provide an account of their experience of using the MHPS Framework. Information was provided by the Northern, South Eastern and Southern Trusts, as well as by the Business Services Organisation (BSO), representing smaller HSC organisations. Many of

665 WIT-42376, paragraph 39
666 WIT-42377, paragraph 43
667 WIT-42381 to WIT-42390 paragraphs 60-73, Mr May identifies the key issues raised with the MHPS Working Group between 2011-2013
668 WIT-42391, paragraph 77

the problems which had been reported to the Department as part of its earlier review continued to burden the Trusts. Mr May explained that three broad issues emerged from the material submitted to the Department in 2018: it took too long to go through each of the steps required by the Framework; there was a need for greater clarity with regard to the roles of those involved in a MHPS investigation, including NCAS, the Case Manager and the Case Investigator; and there was uncertainty surrounding professional groups caught by the scope of the policy.[669]

326. The Inquiry heard how the Trust contributed to each of these initiatives. On 15 January 2013, Dr Simpson, then Medical Director of the Trust, wrote to the Department raising a number of issues including the impact of legal representation; the inevitability in most cases of a protracted process; concerns about doctors leaving the employment of the Trust when the MHPS process had not reached a conclusion; and the challenges around establishing independent disciplinary and clinical performance panels.[670] On 15 March 2018, Ms Parks, (Head of Medical Staffing), informed the Department that it was the experience of the Trust that the MHPS arrangements hampered the Trust's ability:

> "to take quick effective action where there are serious concerns about the misconduct or capability of medical staff."[671]

She went on to note that the MHPS Framework "sets timescales that Trusts can very rarely comply with."[672] Ms Toal, Director of HR, added a further comment to indicate that she had experienced difficulty with the role of the NED during MHPS cases. She explained that:

> "the document is not clear and at times we have got completely muddled as to what their role actually is and how far they can go when contacted by a doctor going through a process."[673]

669 WIT-42394 to WIT-42395, paragraphs 86-90
670 WIT-43161 to WIT-43162
671 WIT-43009 to WIT-43012
672 WIT-43011
673 WIT-42998

Mr May described the Trust's engagement in 2018 as the "most substantial input" of the several received by the Department in the context of its request for information.[674]

327. In its submissions to the Inquiry, the Trust has contended that many of the structural problems with MHPS which have been exposed during this Inquiry, "had already been highlighted" in the contributions made by the Trust and other Trusts to the Department as part of the aborted reviews in 2011-13 and 2018.[675] The Inquiry acknowledges that this is a largely accurate observation. It is, therefore, regrettable that the Trust was left to wrestle with the unrevised policy in its application of MHPS to Mr O'Brien's case. In many respects, the policy was unfit for purpose. Of course, that is not to ignore the fact that many of the failings which we have identified in the application of the policy to Mr O'Brien's case could have been avoided by the Trust. It is regrettable that over a period of many years there had been no reform of the framework and no revised guidance on how it should be applied.

328. In his evidence to the Inquiry, Mr May attempted to explain why the reform initiatives launched by the Department in 2011, and again in 2018, were left uncompleted. It appears that on both occasions the Department was blown off course by capacity issues and competing priorities.[676] The Inquiry appreciates the many demands placed upon the Department and its officials; it is a Department with a wide-ranging and demanding remit. Nevertheless, the failure to complete the task of reforming MHPS cannot be excused on this basis. The HSC employers, including the Trust, depended upon the Department to lead change in this area and change was not forthcoming. Whilst a further review of MHPS in Northern Ireland was published in July 2024, a thorough review of the

674 WIT-42395, paragraph 88
675 SUB-00055, paragraph 4.39(g)
676 See the explanation set out by Mr May at WIT-42380, paragraph 55, in respect of the 2018 failure to complete a review, and see the explanation set out at WIT-42390, paragraph 75, in respect of the 2011-2013 failure

MHPS Framework ought to have been a priority for the Department long before then.

329. In July 2024, the Review Panel (as mentioned in paragraph 129) produced a report, entitled *Review of Maintaining High Professional Standards in Northern Ireland* (the Review).[677] The Review concluded that MHPS is "no longer achieving the intended purpose" and advanced some 24 recommendations for its improvement.[678] We endorse all of those recommendations.

330. There has been some debate as to whether it is appropriate for doctors to be treated differently to other employees of HSC Trusts. The main argument for doing so appears to be that unfair treatment can end a doctor's career. We consider that the same argument can readily be made in respect of other professionals, and we are unconvinced that this argument should be determinative of the need for an MHPS process.

331. Arguments have been made that, in the absence of a revocation and fundamental rewrite of the Framework, the Department should unilaterally withdraw from its agreement and produce a new, fit for purpose recommended procedure.[679] In our view, a less complex procedure would benefit both the doctor and the employer.

332. Serious issues affecting patient safety require to be communicated to and shared appropriately between Health and Social Care Trusts. The Inquiry recommends that a mechanism for ensuring that this is done be agreed by all Trust ROs.

333. If it is suspected that a doctor is in difficulty, whether because of performance or conduct issues, the medical manager with responsibility for the doctor must immediately seek advice from the HR Directorate.

677 DOH-72564 to DOH-72702
678 DOH-72569 to DOH-72574
679 See: It's time to ditch MHPS | Bevan Brittan LLP, an article by Alastair Currie, Partner in Bevan Brittan LPC, published on HSJ.co.uk dated 29 March 2017

334. The Inquiry considers that MHPS is not fit for purpose and ought to be replaced in line with the recommendations of the Review Panel. In particular a single policy mechanism for addressing performance issues should be developed, which applies equally to medical and non-medical staff. The following points relating to HR input, definition of key roles, allocation of resources, training, audit and so forth, should be factored into the development of any such policy.

335. In the interim or if it proves impossible to replace the MHPS Framework then the following must be considered:

- The key principle underpinning the MHPS framework is the essential primacy of patient safety. In the event of conflict between the clinician's needs or interests, patient safety must be prioritised ahead of subsidiary considerations such as the doctor's wish for confidentiality.

- The distinction between a formal and informal process within MHPS is unhelpful, is not easily achieved in practice, and should be removed.

- The reference to a four-week time frame for the completion of MHPS investigations is unachievable in the vast majority of cases and its continued inclusion in the framework creates unrealistic expectations. It should be removed.

- Accountability and reporting arrangements must be enhanced. An audit mechanism should be introduced in respect of MHPS investigations, such that progress, cost and actions taken can be monitored. These audits should be reported to the Trust Board.

- The nature, extent and duration of the responsibilities of those who carry out key roles in the MHPS process should be clarified. This includes the Oversight Committee, the Case Manager, the Case Investigator and the Designated Non-Executive. Additionally, efforts should be made to describe the roles of

other key stakeholders including the Medical Director and the Lead Officer within the HR Directorate.

- The Trust must ensure that those appointed to perform roles under the framework are afforded sufficient protected time in their job plans to do so properly and efficiently.

- The Trust must ensure that appropriate training and skills development is available to those who are asked to carry out roles under the MHPS framework.

- A register of those who have completed relevant training should be maintained.

- If the individual who is subject to investigation is unwilling or unable to co-operate with the requirement for timely engagement with the process, whether by attending an interview or finalising a written response, the matter should be escalated to the Medical Director who should intervene in their role as RO with a view to compelling proper engagement.

- When a Determination has been reached at the conclusion of the MHPS process, the individual with responsibility for delivering any recommendations must be clear. Moreover, the process of implementation should be kept under review and should be the subject of report to the Trust Board.

- If the outcome of a MHPS process is challenged, for example via the employer's grievance process, this should not interfere with, or prevent implementation of, measures designed to address patient safety concerns.

Contents – Chapter 3 – Clinical Aspects

(*c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty*.

Introduction

1. It was the serious concerns with Mr Aidan O'Brien's practice at the Trust that led to the then Health Minister Mr Robin Swann announcing on 24 November 2020 that there would be a Public Inquiry. That announcement resulted in the setting up of this Inquiry, whose Terms of Reference (ToR) focus not primarily on Mr O'Brien's work and practice but on patient safety issues and the governance shortcomings in the Trust that impacted on patient safety.

2. The Inquiry was tasked by ToR (c) to examine the clinical aspect of those cases which met the threshold for SAIs identified by the time it commenced its work. Once we received material, we considered that such cases included the nine SAIs that led to the Inquiry being announced, and the SAI involving five patients that reported in 2020. We were further tasked to examine any other appropriate cases. The Inquiry considered this included looking at the thematic results arising from the Structured Clinical Record Reviews (SCRRs) (albeit these were only concluded after we commenced our work) as outlined in the Trust's Outcome Reports[1] and the findings of the Royal College of Surgeons of England (RCS) Report.[2] There were also a few discrete cases disclosed in evidence that we considered relevant.[3] In addition, the evidence disclosed clinical practices that had been identified and dealt with by the Trust.[4]

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1 TRU-409761 to TRU-409787: "Southern Health & Social Care Trust Urology Lookback Review Activity & Outcomes Report (Cohort 1)" and TRU-414178 to TRU-414201: "Southern Health & Social Care Trust Urology Lookback Review Activity & Outcomes Report for Cohort 2"
2 TRU-157783 to TRU-157902
3 Patients 90, 92 and 95
4 EG: The use of IV antibiotics discussed below

3. The point was made repeatedly by the Chair in public statements and during the Inquiry's evidence sessions, that while Mr O'Brien's work was the catalyst for the Inquiry, it was not part of our ToR to determine whether individual patients of Mr O'Brien received inappropriate or substandard treatment. The Inquiry was not resourced for such work, and moreover both the Inquiries Act 2005 and its terms of reference prevent it from doing so. The Inquiry cannot determine criminal or civil liability, that is a matter for the courts.[5] Any determination as to an individual doctor's fitness to practice is properly the domain of the General Medical Council (GMC) and, as the ToR state, it would be inappropriate for the Inquiry to encroach on the GMC's remit. Instead, as the ToR make clear, the focus for the examination of the clinical aspect of cases was to identify any failings in the systems of governance within and relating to the Trust's urology specialty which may have affected patient care and safety. This was a key aspect of the Inquiry's work, as individual clinical decisions, when unchecked by governance, can lead to systemic patient safety risks.

4. It is notable that the serious incidents did not come to light through normal governance procedures; more is said about this in the Governance chapter. During the investigation of the nine SAIs and the look back that followed, it was clear to the Inquiry that there had been a tolerance of poor adherence to fundamental professional standards.

5. Although the specific cases brought before the Inquiry related mainly to a single practitioner in a single specialty, the Inquiry considered the failings to be relevant more generally to the oversight and support for high standards of professional practice in the Trust. The extent of deviation from normal standards of practice was not apparent for a variety of reasons which the Inquiry has drawn out in evidence and which is explored in consideration of the Trust's clinical governance elsewhere in this Report, including in the chapter on Maintaining High Professional Standards (MHPS).[6] In any event the failings resulted both in patient harm and in the risk of patient harm and the Inquiry has therefore sought to

5 Section 2 of the Inquiries Act 2005
6 MHPS and Governance chapters

determine where this should have been detected, by whom and what missed opportunities are evident.

6. In the material brought before the Inquiry there is evidence that the overall systems of governance were not equipped to detect the failings that occurred and that the overall culture of management and leadership was not sufficiently patient and patient safety focused to mitigate risks to patients.

7. Neither the Trust nor any specific individual set out to cause harm to patients but there were individuals who played a part at each level of leadership and management who should and could have acted differently. The overall operational difficulties and pressure on services was also a very significant contributing factor. The emphasis on performance targets skewed priorities and led to a certain degree of institutional blindness.

8. The Inquiry considers that, if the governance structures had been more secure; if the cultural focus, from the Board through to each service, had been more patient safety focused; and if the voice of patients and of front-line staff was considered in a more systematic fashion; then things may have been different despite the operational pressures in play.

9. The Inquiry was concerned to learn that when the issues regarding Mr O'Brien's practice came to light, the Trust did not consider it appropriate to look at the service more broadly to assure itself that there were no problems with the practice of any of the other clinicians. It ought not to have been difficult to carry out some audits or investigations to confirm its assumption that there were no problems with any of the other clinicians. Of course, had there been a range of regular quality metrics this would have been clear. The Inquiry considers that a wider audit of practice in Urology would have been appropriate.

10. Nonetheless, as it was solely Mr O'Brien's practice that led Minister Swann to announce the Inquiry into those clinical and governance issues, and he was the only consultant within the Trust's urology service to be named in the Inquiry's ToR,

the Inquiry considered it appropriate to designate Mr O'Brien as a core participant before it.

11. Doing so proved to be advantageous for the Inquiry in that Mr O'Brien, fulfilling his requirement under the Section 21 Notice served on him, provided the Inquiry with valuable information that assisted the Inquiry in its work.

12. The triggering incidents for this Inquiry were related to patients of a single practitioner in the specialty of urology. The Inquiry has, therefore, considered evidence from clinicians and administrative staff relating to how that specialty was managed and led and the way the care in that department was delivered. This evidence has enabled the Inquiry to consider the everyday reality of clinical work in urology and the perspective of front-line clinicians including that of Mr O'Brien. It is through this process that the Inquiry has sought to understand the thematic issues in failings of clinical practice that should not have gone undetected and the reasons why they were either undetected, or alternatively, not dealt with appropriately.

13. The Trust urology team had its own ways of communicating and learning and had its own governance arrangements. These included departmental meetings, a patient safety committee, and the urology cancer multidisciplinary team meeting. The work of the team was performed within a clinical governance framework which provided a system to report practices or incidents and other things which gave rise to harm or risk of harm, however it lacked any proactive measurement of quality.

14. The Inquiry looked at how the urology service worked together as a team and individually. A department needs to be unified around a specific purpose to provide excellent clinical care. A service where individuals work in silos is bad for patient safety.

15. The Inquiry looked at whether, aside from the failings that can be laid at the door of the Trust, Mr O'Brien himself bears any responsibility for what occurred.

16. The evidence considered has also allowed the Inquiry to form a view regarding how well the Trust supported the right environment for clinicians to flourish and to be able to fulfil their professional responsibilities.

17. Although, as has been stated, the Inquiry did not set out to form a judgement regarding culpability for failings in any individual case, the Inquiry did consider the clinical matters revealed by the serious incident and look back investigations, and the professional matters that came to light as a result of those processes. These matters have been accepted by the Trust and the Department and the Inquiry did not seek to reinvestigate or challenge the conclusions of those investigations, but rather sought to understand the causes of the weaknesses in governance processes that allowed key issues to go undetected, or to occur recurrently, with a view to making recommendations for action by the Trust and others.

18. The evidence presented to the Inquiry from clinicians in urology reflects broad issues impacting on patient safety and quality of care in the Trust more widely.

19. It is the responsibility of medical leaders within any health trust to deal with professionals who are in difficulty and we heard evidence as to how those in medical leadership dealt with Mr O'Brien over the years.[7] Unfortunately, it would appear that the medical leaders failed to intervene appropriately. More is said about this in the Medical Management and Leadership chapter. Some operational leaders attempted to intervene but found this difficult and essentially only achieved temporary changes.[8]

20. We heard evidence, in particular from Dr Maria O'Kane, about changes that were instigated in the Trust as a result of the work of this Inquiry to try to improve the

7 Discussed in detail in the chapter on MHPS

8 See example of the interventions of Dr Rankin in ensuring that Mr O'Brien completed triage before he would be permitted to attend a conference abroad. WIT-15827 to WIT-15828, paragraph 30.2a

culture in the Trust.[9] It was clear to the Inquiry that she recognised the need to keep the focus on patient safety and empower staff to speak up when necessary. The Inquiry considers that while Chief Executive she took steps to introduce a 'just culture'[10] and improve the Trust's approach to safety. We consider that more needs to be done and this is discussed in more detail elsewhere in this Report.[11] In essence, patient safety needs to be so embedded in Trust processes and practices that it makes it almost impossible not to do the right thing. Ensuring this is the case starts with the Trust Board and filters down to all services and is reflected up the chain through information systems to Board level.

Background to the Trust's urology service

21. The Trust has been providing a urology service for patients living in the southern part of Northern Ireland since 1992. Prior to 1992, fully trained urologists were based at Belfast City Hospital (BCH) and the Royal Victoria Hospital. In 1992 urologists were appointed at Craigavon, the Mater and Altnagelvin Hospitals. In Craigavon, the appointee was Mr O'Brien.

22. Mr O'Brien graduated in medicine from Queen's University Belfast in 1978. He undertook postgraduate surgical training in Northern Ireland. He was appointed as a Registrar in Urology at BCH in 1984, St James's Hospital Dublin in 1985, in 1986 he was appointed research fellow at Meath Hospital, Senior Registrar in 1988 and he went on to complete Higher Surgical Training in Urology on 30 June 1991. He was then appointed Senior Registrar in Paediatric Urology at the Royal Hospital for Sick Children in Bristol on 01 September 1991. In a two-month interval prior to taking up his role in Bristol, Mr O'Brien served as a locum consultant at Craigavon Area Hospital (CAH) for seven weeks. After a competitive interview, Mr O'Brien returned to Craigavon to take up post as Consultant Urologist on 06 July 1992. He worked in that capacity until July 2020 when he left the Trust's employment.[12] Mr O'Brien was initially joined at Craigavon in 1996 by

9 TRA-11624, line 18 to TRA-11651, line 21
10 See Governance and Medical Management and Leadership chapters
11 See Governance and Medical Management and Leadership chapters
12 AOB-01879 to AOB-01880. The Trust considers that Mr O'Brien retired – he disputes this

Mr Wahid Baluch, then in May 1998 by Mr Michael Young and in 2007 by Mr Mehmood Akhtar.

23. A review of adult urology services was published by the Health and Social Care Board (HSCB) in March 2009.[13] A submission to the Minister of Health, subsequent to the completion of the review, dated 23 April 2009, indicated that the review was initiated:

> "in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services."[14]

24. The aim of the review was to:

> "Develop a modern, fit for purpose in 21 century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care."[15]

25. The review was to mark a significant change in the delivery of urology services in Northern Ireland. From 01 January 2013, those services were built around a three-team model, Team East, Team North, and Team South. As part of this remodelling the Trust – Team South - took on responsibility for the provision of urology services to the population of County Fermanagh. The review report argued that this reorganisation was necessary "to achieve long term stability and viability."[16] The statement of Mr Ryan Wilson, amongst others, provides a high-level account of the review of urology services.[17]

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13 WIT-50807 to WIT-50870
14 WIT-50784 to WIT-50800
15 WIT-50814, paragraph 2.4
16 See extracts from Submissions to Minister at WIT-50794; WIT-50894
17 WIT-50716 to WIT-50721

26. The review led to the recruitment of additional consultants, Mr Anthony Glackin joined in 2012; Mr David Connolly joined in 2012 but left in 2013; Mr Ajay Pahuja joined in 2012 but left in 2014; Mr Ram Suresh joined in 2013 but left in 2016 and Mr Mark Haynes and Mr John Paul O'Donoghue joined in 2014. From August 2014 the Trust urology team had six consultants until Mr Suresh left in October 2016. There had been no applicants for the substantive post until February 2019 when Mr Matthew Tyson joined the team. Mr Tyson had a pre-arranged one-year fellowship from Autumn 2019 and, due to Covid, was unable to return to his Southern Trust post until 24 October 2021.

27. As stated in the Introduction to this Report, the urology service sits within the Trust's Acute Directorate, and patient care is delivered across multiple Trust sites. The main setting for the provision of the Trust's urology service is Craigavon Area Hospital (CAH), where services are provided by a team of consultant urologists, Clinical Nurse Specialists (CNS),[18] staff nurses and allied health care professionals, in addition to pathologists and radiologists. The urology service provided at Craigavon encompasses the main facets of urological investigation and management with some exceptions including radical pelvic surgery, renal transplantation and associated vascular access surgery, which are provided by the Regional Transplantation Service in Belfast. Additionally, neo-natal and infant urological surgery is provided by the Regional Paediatric Surgical Service in Belfast.[19]

28. The Trust has a purpose-built urology outpatient facility located in the Thorndale Unit. It is run by five CNSs. Outpatient services at Craigavon include urodynamics, ultrasound, intravesical therapy, prostate biopsy and flexible cystoscopy. Craigavon Hospital has been designated as a Cancer Unit, with its Urological Department being designated the Urological Cancer Unit for the area's

[18] The Clinical Nurse Specialists in the Urology Department dealt with patients with benign conditions and cancer patients. For clarity, this Report uses CNS to refer to their dual role and as key workers as part of the urology CNS role for those engaging in oncology activity. See evidence of Ms O'Neill at WIT-80914 to WIT-80915

[19] TRU-98101

population. A wide spectrum of urological cancer management has been provided for some time. Outreach clinics are currently provided in a few locations in the Trust area.

29. The urology service is managed within the Acute Services Directorate. On the operational side there is a Head of Service (HOS)[20] who acts as the direct link between the urology service and the staff members who manage individual areas/departments within the Trust where urological clinical activity is delivered. She provides day-to-day operational management with regard to the activities delivered by the urology team, with support from the Clinical Lead (CL) for the service or the Clinical Director (CD). The HOS is accountable to the Assistant Director for Surgery and Elective Care.

30. The urology service has long been troubled by an inability to fill all available posts. This has impacted on the provision, management and governance of urology services. The inability of the Trust to fill its consultant vacancies in urology has resulted in a reduction in clinical activity, which in turn has been a factor in the increased waiting times. Additionally, the pressures on the current group of consultants is increased so that, for example, they are required to cover the Urologist of the Week (UoW) service more frequently, and that in turn has an adverse impact on the time spent in theatre and in clinic. Understandably, the inability to meet demand leads to ongoing patient complaints and challenges which have to be managed.[21]

31. The Inquiry heard from all the clinicians and from several managers about the difficulties in recruiting and retaining, in particular consultants, to the service.[22] Unfortunately, the difficulties with recruitment and retention continue to impact the service. On her final day of oral evidence Dr O'Kane advised the Inquiry that three

20 At the time of the events relevant to the Inquiry this role was performed by Ms Corrigan. Ms Wendy Clayton took over from her in October 2020 as Interim Head

21 See witness statement of Ms Clayton at WIT-32285

22 TRA-08103, line 20 to TRA-08105, line 21; TRA-08525, line 11 to TRA-08527, line 24; TRA-09007, line 6 to TRA-09008, line 21; TRA-11722, lines 2-15

consultants had been recruited from India after an effort that included clinicians going with Human Resources (HR) staff to India. [23]

32. The Trust advised the Inquiry in response to a query that of those three, one started at the beginning of June 2024 and left the Trust at the end of April 2025. Another, who started mid-February 2024 left at the end of August 2025. One of the recruits started in May 2024 and remained in post together with Mr O'Donoghue and Mr Haynes (whose time is split between the Belfast and Southern Trusts). Mr Glackin left the Trust in June 2025 and will be replaced by a long-term locum.

33. Clearly the Trust continues to have difficulties retaining consultants. Reasons appear to include the excessive workload, an inability to develop a subspecialty and lack of middle grade support. This is not unusual in smaller NHS hospitals in GB. The effect of this on the viability of the service is concerning. The Inquiry considers that the Department is aware of the very significant workforce challenges and has supported a number of initiatives to improve matters. Nevertheless, the problem remains and consideration should be given to developing programmes that provide more assistance with the recruitment and retention of staff within specialties generally. Where there appears to be a particular difficulty, as here with the Trust's urology service, the Department ought to consider alternative, regional methods of delivery. The Inquiry notes that the use of Lagan Valley to reduce waiting lists for certain elective procedures, such as laser stone surgery and laser prostate surgery, performed either as day surgeries or overnight stays, has been successful and would encourage more such innovative practices.[24]

34. As stated above, the Inquiry had the benefit of receiving evidence from Mr O'Brien. He provided numerous pages of material. He provided the Inquiry with an original Section 21 response dated 02 November 2022,[25] an addendum

23 TRA-11902, lines 17-22
24 See evidence of Mr Glackin at TRA-08102, lines 14-28
25 WIT-82373 to WIT-82657

statement dated 31 August 2023[26] and a further addendum statement submitted prior to Mr O'Brien's return to give evidence to the Inquiry for a second time in April 2024.[27] He gave evidence to the Inquiry on six days, both in relation to the MHPS investigation into his practice and into issues relating to his practice more generally. We had the benefit of seeing relevant material provided by the Trust that included emails and letters sent by Mr O'Brien and others, and we had the benefit of hearing from those who worked closely with him over his career.

35. In his statement to the Inquiry, Mr O'Brien provided a description of the developments in the urology service in Craigavon from when he took up his post.[28] Mr O'Brien reflected that the appointment of a second consultant was:

> "a necessity at that time as it had otherwise become impossible for a single consultant urologist to provide an adequate service to meet the increasing urological needs of the population".[29]

36. Mr O'Brien suggested that:

> "The Urological Department at Craigavon Area Hospital had been remarkably successful in its first decade, and was widely recognised throughout Northern Ireland for being so."[30]

37. Mr O'Brien explained in his evidence that despite the expansion in the number of consultants employed at what had by then become the Southern Trust, there were enormous difficulties in meeting demand.[31] He said that:

> "the operating capacity allocated to the Urological Service had not been correspondingly increased"[32]

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26 WIT-98807 to WIT-98808
27 WIT-107564 to WIT-107623
28 AOB-01880
29 AOB-01880
30 AOB-01881
31 AOB-01884
32 AOB-01884

in response to the number of referrals which accumulated annually, leading to increased waiting times for surgery.

38. Mr Haynes, Consultant Urologist, joined the urology team in the Trust in May 2014, after the three-team model had been implemented. Mr Haynes explained that the Trust's urology output "does not exist as a separate self-contained entity" but, rather, it is a service which sits within the Trust's Acute Directorate, and patient care is delivered across multiple Trust sites including CAH, Daisy Hill Hospital, South Tyrone Hospital, Southwest Acute Hospital and Banbridge Polyclinic.[33]

39. Mr Haynes also expressed concerns to the Inquiry regarding the resources which have been devoted to servicing the three-team model. It was his view that:

> "The service was effectively commissioned at a level where it would fail to meet population need from its inception and this gap would widen given the absence of projections related to increasing demand resultant from population / demographic changes."[34]

He claims that this:

> "is the pattern across Urology in Northern Ireland and remains the case."[35]

40. Mr Glackin told us:

> "Theatre provision across the Craigavon site is inadequate for the demands of a modern urology service. When I arrived in 2012, we shared nine half-day in patient lists across the team of five Consultants. In an effort to improve waiting lists, we collectively worked extra Saturdays. For a time this worked well

33 WIT-53896, paragraph 30.1
34 WIT-53878, paragraph 13.2
35 WIT-53878, paragraph 13.2

however, within a few short years the year round bed crisis made this activity impossible. Another factor that hampered this effort was that the theatre nurses were expected to undertake this work as part of their normal shift pattern and were not paid additionality like the medical staff. In an effort to improve in patient theatre access 3 session days were trialled on Tuesdays and Wednesdays. This was not sustainable in the long term due to staffing issues from an anaesthetic and nursing perspective. The productivity of the 3 session days was not as good as we had hoped. In my view job planning for each Consultant Urologist should include 3-4 theatre sessions per week with a mix of in-patient and day case sessions to deliver the needs of the patients. For a team of 7 Consultants this would mean 21-28 sessions per week, a more than doubling of our current provision."[36]

41. The Inquiry heard from Mr Young who described the demand-capacity mismatch as a persistent issue, leading to delays in treatment and increased risks for patients.[37] Mr Young said that the problem with the plan for Team South was that "there was an overestimation of the actual workload capable".[38] He described multiple attempts to draw attention to this and propose solutions.[39]

42. He explained that routine patients often became emergencies, which consumed more resources and time. He emphasised that staffing shortages and lack of theatre access created a vicious cycle where delays led to more complex cases. Mr Young also noted that consultants were stretched, often covering for absent colleagues and working beyond contracted hours. Mr Young told the Inquiry that chronic understaffing led to disjointed patient care and reduced productivity. oncology cases were prioritised, leaving benign but urgent cases (e.g., catheter patients) at risk.[40]

36 WIT-42297, paragraph 15.5
37 TRA-08990, line 23 to TRA-08991, line 27; WIT-51684, paragraph 1.8
38 WIT-51710, paragraph 10.6
39 WIT-51711, paragraph 11.1 to WIT-51714, paragraph 11.13
40 WIT-51732, paragraphs 17.3 to 17.6

43. Clearly there has been increasing difficulty in servicing the urology needs of the population served by the Trust and, indeed, regionally.[41] Where demand outstrips capacity there is a greater need for sound governance processes that can ensure, as far as possible, that patients on waiting lists remain safe and that a safe service is provided by those tasked with delivering it.

44. The reaction of individuals in relation to the demand capacity mismatch varied. Many adapted their working practices, for example with regards to triage they moved to streamlining their processes[42] and reduced the number of follow up visits to try to see more new patients. Mr O'Brien's reaction was to try to carry out more surgery in an effort to reduce the numbers waiting, this had a knock-on effect on other aspects of his work and he failed to adapt those to compensate. While triaging Mr O'Brien telephoned many patients thereby greatly increasing the time required to complete this task. Also, according to Ms Martina Corrigan, the time taken to see patients during clinics varied, Mr Haynes managed to see 16 per follow-up clinic, others about 14 and Mr O'Brien about eight.[43] Mr O'Brien disputed the accuracy of this statement. The Inquiry did not see any robust comparative data regarding clinics.

45. In a submission made for the purposes of the formal grievance which he raised at the conclusion of the MHPS process[44] (01 December 2018), Mr O'Brien outlines that the demands on his time:

> "became more acute owing to additional pressures that built up between 2012 and 2016."[45]

He had been appointed as Lead Clinician of the Northern Ireland Cancer Network's (NICaN) Clinical Reference Group in Urology in January 2012 and

41 AOB-00027 to AOB-00035; WIT-52121 to WIT-52143; TRA-00341, line 25 to TRA-00343, line 23
42 TRA-00859, lines 4-16: Eg Mr Haynes devised a series of standardised letters to speed up his practice
43 TRA-07411, lines 16-19
44 The MHPS process and how it was handled is dealt with in the MHPS chapter
45 AOB-02029

Lead Clinician of the Trust Urology Multidisciplinary Team (MDT) and Chair of the Urology Multidisciplinary Meeting (MDM) in April 2012. He stated that his duties in the latter role required him to chair 137 meetings which necessitated a conservatively estimated 480 additional hours of administrative work undertaken in his own time.[46] He also had to take steps to prepare the urological oncology service for National Peer Review in June 2015. He pointed out that there had been a reduction in his patient related administration time to two hours per week by 2016.

46. Mr O'Brien outlines that, despite raising these pressures with Ms Corrigan, then HOS, on more than one occasion:

> "no remedial or supportive plan or action was put in place to alleviate me of this overwhelming burden, which then gave rise to an administrative backlog in terms of dictation of letters, and which became a subject of concern."[47]

47. The Inquiry is cognisant that Mr O'Brien was a doctor in difficulty and ought to have received assistance. More is said about this in the Medical Management and Leadership chapter. Essentially, Mr O'Brien ought to have had an agreed programme of help or remediation put in place.

Clinical aspects and methods of practice

48. To fulfill term (c) of its ToR, the Inquiry had to consider what was meant by the words 'clinical aspect'. The Inquiry determined that it was appropriate to interpret term (c) by looking at the evidence to see whether there were significant clinical shortcomings in the cases considered or in the evidence generally, which presented a risk to patient safety and quality of care. We did this by looking at several matters. As indicated above we did not seek to re-investigate the SAIs or other cases. We did, however, look at those findings generally to see what they

46 WIT-82430
47 AOB-02030

told us about shortcomings in clinical practice, the urology service and the governance thereof.

49. As the cases largely related to patients of Mr O'Brien's, it was necessary to reflect on Mr O'Brien's actions generally, although, for the reasons articulated above, not in terms of whether his treatment of an individual was appropriate, but rather to see whether there were general deviations from good practice and shortcomings in his approach to patient care. We were conscious that the SAI investigations had already assessed there to be shortcomings in the cases it looked at, and that the RCS Report[48] and the SCRR outcome reports made similar findings.

50. The Inquiry looked at what the appropriate standards for practice are by reference to the GMC guidance to doctors and consultants, national guidance and Trust policies. We also questioned Mr O'Brien's colleagues and others about their clinical practices.

51. Good clinical care for urological patients depends on a number of steps performed in a timely fashion from General Practitioner (GP) referral to attendance, diagnosis and treatment by the urologist.

52. Good non-cancer care depends on timely outpatient assessment and investigation followed by timely and efficient surgical or medical treatment where this is deemed necessary.

53. Good cancer care additionally requires timely accurate diagnosis, a fully functioning quorate MDM, prompt review following MDM to offer the agreed options and then activating these options with good support from CNSs and regular, appropriate follow up. Referrals to clinical or medical oncology colleagues should be made for specialist care as defined by Improving Outcomes Guidance (IOG) and NICaN Guidelines. Additionally, a core part of good cancer care is that

48 TRU-157783 to TRU-157902

all clinicians adhere to relevant extant standards and guidelines for treatment, eg: those issued by the National Institute for Clinical Excellence (NICE). Waiting times for cancer patients needing surgery should be short and mechanisms for cross referral to specialist surgical and oncology colleagues should be streamlined. The target for time to start treatment after referral for suspected cancer is well established at 62 days. This is the target set out by the NICE and the NICaN Guidelines.[49]

54. Overall sound clinical management in both scenarios also relies heavily on good communication, a responsive and accessible secretariat and efficient administration systems to schedule surgery and outpatient appointments.

55. The evidence before the Inquiry led us to conclude that there was not always good clinical care delivered in the Trust's urology specialty.

56. The Trust had a series of governance structures in place but there was a lack of coherence in terms of how they functioned. There was an absence of understanding of the overall aims, values and vision of the Trust. Improvements are needed in this area, but poor systems of governance do not absolve senior staff from adhering to the standards set by their professional bodies.

57. The GMC is the UK's independent regulator of doctors. All doctors who practice medicine in the UK must be registered with the GMC and periodically, that registration must be revalidated. As stated above, the Inquiry is precluded by its ToR from encroaching upon the work of the GMC in relation to its investigations into Mr O'Brien's fitness to practice.

[49] Improving Outcomes Guidance: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf; NICaN Guidelines: TRU-98371 to TRU-98523; NICE Guidelines: TRU-349030 to TRU-349115

58. That said, the GMC sets professional standards for doctors. 'Good Medical Practice' (GMP)[50] is the GMC's core guidance to medical practitioners and sets out the standards of care and behaviour expected of all professionals. The Inquiry considered that the GMP guidance was a useful tool to be used in assessing Mr O'Brien's practices generally.

59. As stated, the Inquiry does not make any determination as to causation in the harm identified by the SAIs or any other case. 'Clinical aspect' does not require an in-depth examination of any individual's clinical treatment and the Inquiry has not looked at Mr O'Brien's management of individual cases in that way. We have nonetheless had regard to his comments on the SAIs and the evidence he has given to us whether documentary or oral.

60. In considering the clinical aspect of the cases taken into account, the Inquiry looked to see whether there was deviation from the guidance set out by the GMC in GMP 2013-2024[51] and the GMC's Guidance on Leadership and Management.[52]

61. There is a wide range of professional obligations contained in the GMC guidance and it is both the responsibility of the doctor to comply with these obligations and the responsibility of the employer to ensure that the doctor is given the tools and support to do this. This requires strong clinical governance systems coupled with strong medical management and leadership in an organisation where the focus is on patient safety, quality and improvement and learning. This was lacking in the Trust.

50 The guidance that the Inquiry has seen was published on 25 March 2013 and came into effect on 22 April 2013, see INQ-30867 to INQ-30906 and also WIT-13934 to WIT-13973. It was updated in April 2014 and April 2019. A new version was issued on 22 August 2023, coming into effect on 30 January 2023 and was updated on 13 December 2024. Unless otherwise stated references in this Report are to the version updated in 2019.

51 This was revised in January 2024, but for Inquiry purposes the relevant document was issued in 2013 and is at INQ-30867 to INQ-30906.

52 INQ-30846 to INQ-30866

62. The GMC documents also make it clear that part of providing good medical care to patients relates to the need to communicate with patients and colleagues, the need to work collaboratively with colleagues and the need to understand and follow the policies set out by employers relating to governance. In other words, being a good doctor is not just about being adequately trained and knowing how to diagnose and treat a patient, and being a good surgeon is not just about being skillful in the operating theatre.

63. Being a good doctor also entails having good administrative practices. The Inquiry noted that Domain 1 of the GMP includes the following guidance relating to record keeping:

> "**Record your work clearly, accurately and legibly**
>
> 19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
>
> 20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.
>
> 21 Clinical records should include:
>
> a relevant clinical findings
>
> b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
>
> c the information given to patients
>
> d any drugs prescribed or other investigation or treatment
>
> e who is making the record and when."[53]

64. Not adequately recording the details of a clinical encounter presents a risk to patients. The Inquiry therefore looked at whether there were failings in

[53] INQ-30877

administrative practices generally by Mr O'Brien. We considered that the evidence gathered during the MHPS investigation into his administrative practices clearly established that, as he admitted, he did not dictate after all clinics in a timely way, he did not triage all the cases that were his responsibility to triage while UoW and that he kept patient files at home that ought to have been kept within the hospital.[54]

65. In addition, Mr O'Brien admitted in an exchange with Inquiry Counsel that he did not record what discussions he had with his patients regarding their treatment in their notes:

> "A. And in case I gave the wrong impression, it's not that I didn't record it in the chart. I mean I wrote out all of the risks and benefits for the patient and gave it to them, in addition to the information booklets and so forth.
> Q. But it's not in the notes, is it?
> A. But not in the notes. Yeah.
> Q. Hmm. And looking back on that, do you think you could have just photocopied it and put it in the notes, couldn't it? [sic]
> A. Yes. I could have done, yes.
> Q. Okay.
> A. If I'd known actually I was going to be asked that question at a public inquiry I would certainly have insured it at the time, yes."[55]

66. We further considered whether there was evidence of failure to follow clinical guidelines that would have the potential to harm patients. After reading the material provided and listening to all the evidence the Inquiry is satisfied that Mr O'Brien did not always follow clinical guidelines. This was particularly evident in his unlicensed use of Bicalutamide.[56]

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54 GMC guidance – "Confidentiality: good practice in handling patient information" came into effect on 25 April 2017 and was last updated on 13 December 2024. It states at paragraph 122: "You must develop and maintain an understanding of information governance that is appropriate to your role." See INQ-31039 contained in guidance at: INQ-31009 to INQ-31059

55 TRA-12651, line 24 to TRA-12652, line 10

56 See paragraphs 265 to 293 below

67. The Inquiry, being satisfied that there were shortcomings on Mr O'Brien's part, looked to see who knew about them and what, if anything, was done to address those shortcomings. Further, and more importantly, through that examination what did this tell us about the failings of governance and the culture within the Trust? More is said about this in the chapters on MHPS, Governance and Medical Management and Leadership.[57]

68. The evidence before the Inquiry disclosed several issues relating to Mr O'Brien's practice, which led to questions about the governance of patient care and safety within the Trust's urology specialty. Below is a summary of issues brought to the Inquiry's attention in the evidence regarding Mr O'Brien's practices that have been the subject of criticism, assessed against GMC guidance, and by reference to what the Inquiry accepts as common practice among practitioners. Full details of these practices can be found in the transcripts and materials published on the Inquiry's website.

IV antibiotics[58]

69. Mr O'Brien developed a practice of admitting patients for intravenous (IV) antibiotics over several days to prevent or ameliorate recurrent urinary tract infections (UTIs). As part of this regime, he also used subtherapeutic doses of Gentamicin.[59]

70. The GMC requires doctors to follow evidence-based practice.[60] Mr O'Brien's use of antibiotics in this way was not evidence based, rather the Inquiry considers it was an idiosyncratic experimental type of approach which was never the subject of proper audit or assessment.

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57 See MHPS chapter, paragraphs 118 to 124, Governance chapter, paragraphs 366 to 432 and Medical Management and Leadership chapter, paragraphs 126 to 168

58 This is discussed in more detail in the MHPS chapter and ToR(a)

59 See evidence of Dr Boyce at WIT-87655 and TRA-05896 to TRA-05912

60 See GMP, Domain 1: Knowledge skills and Performance at 16b states that a doctor must: "provide effective treatments based on the best available evidence" at INQ-30876, this replaced similar guidance issued in 2006.

71. The Inquiry is of the opinion that this is outside of what would be expected of a consultant in today's health service both now and in 2010/2011 when Mr O'Brien was using the drug in this way. The practice was eventually stopped after significant intervention.

72. Although Dr Vincent Koo published a letter, co-signed by Mr Young and Mr O'Brien,[61] describing the benefits of this method of treating recurrent UTIs and made claims about the efficacy of the treatment, no peer reviewed paper was ever produced. Doctors in a position of seniority have, as in this instance it would appear, made assumptions that seniority and experience allow them to practice without the need for an evidence basis.

73. The practice of admitting patients in this way highlights a significant failing in governance. Clearly there was an inadequate surveillance of the use of antibiotics in the hospital surgical wards. The IV usage was not detected by microbiology surveillance of practice on wards, but rather by a manager looking at bed usage, following receipt of correspondence from an MLA writing on behalf of constituents requesting that they receive the treatment in the community rather than in hospital. It was only then that the pharmacist and microbiologist became involved. Had proper surveillance and monitoring been in place it is likely that the practice would have been identified and scrutinised sooner. Once it was discovered, the Inquiry is of the view that the Trust took appropriate action to resolve the matter and bring it to a satisfactory conclusion in 2010.[62]

74. The GMC mandates that doctors have a duty to participate in clinical governance systems in their organisation.[63] The Inquiry is firmly of the view that using any kind of experimental treatment should be fully discussed at the appropriate governance meeting and that a consensus of clinical advice and audit or monitoring methods should be obtained. The Inquiry notes that Mr Young also brought patients into hospital for antibiotics intravenously to treat UTIs, although

61 WIT-82743 to WIT-82745
62 See MHPS chapter, paragraphs 39 to 60
63 See GMP Domain 2 at INQ-30878

he states his patients had proven infection and the Inquiry has no evidence to the contrary. Mr O'Brien contends that there was no distinction between his patients and those of Mr Young.

75. Mr O'Brien's view was that treating patients pre-emptively in this way would hopefully lengthen the period before which the patient required elective readmission and prevent acute readmission.[64] Mr O'Brien argued in his closing submission that it would have been "beneficial" if there had been a body independent of the Department and its arms-length bodies (presumably by which he means health trusts) to which clinicians could have referred such an issue for investigation. He regrets not insisting that a proper investigation be conducted.[65] Mr O'Brien appears from his submission to be rejecting the appropriate and established methods of medical trials. Moreover, he cites an example of one instance where a patient had to be admitted acutely that could have been avoided: "if compliance with the policy and protocol had not been required."[66] The Inquiry considers that this confirms the view it has formed of Mr O'Brien, that he believes he knows what is best for his patients and ought not to be challenged. Such an attitude, simply put, is very old-fashioned and would not be expected from a doctor in this century.

76. In addition to the failure to use evidence-based medicine, there is the potential for harm to patients in the practice adopted. Intravenous therapy requires access to veins and some patients require special IV lines which could cause complications. Additionally, there is a potential danger in using certain antibiotics in subtherapeutic doses and any inappropriate antibiotic usage can result in resistant micro-organisms. Moreover, beds were being used when there was pressure on beds for other patients.

77. None of these issues were apparently discussed openly before commencing this practice. Since all doctors have a duty to consider all possible harm to patients

64 TRA-12409
65 SUB-00214, paragraph 103
66 SUB-00214, paragraph 104

when any treatment is commenced, ensuring the benefits outweigh the risks, it is particularly important that any unusual treatment is fully discussed. GMP states that:

> "You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance."[67]

The Inquiry has seen no evidence of that being done in this instance.

Cystectomies

78. Cystectomy is a surgical procedure involving the removal of the bladder for both cancerous and non-cancerous reasons. It is typically performed to address severe bladder issues that cannot be managed through other treatments. In 2010 when the Commissioner, through its then Director of Public Health, Dr Diane Corrigan, wrote to the Trust on 01 September 2010 regarding the continued use of IV fluids for patients with UTIs, a concern that a disproportionate number of cystectomies were being performed in the Trust was also expressed.[68] There is no evidence that this practice was widely discussed or audited until a review was mandated following these concerns raised outside the Trust. A review of cases was carried out. The Medical Director (MD) did then act and investigate this appropriately with an external assessor, Mr Marcus Drake who reported in 2011. No definitive conclusion was reached.[69]

79. The Cancer Peer Review process which was conducted throughout the UK and which was considered an important part of improving the standards of cancer care led to the centralisation of cystectomy at the Belfast Trust for patients with bladder cancer. The Inquiry recognises that when IOG was introduced this centralisation of specialist work caused many surgeons to 'rebel' as they had to

67 INQ-30889, paragraph 67
68 TRU-251158 to TRU-251161
69 See evidence of Mr Mackle at WIT-11813 to WIT-11815, paragraphs 203 to 208 and WIT-17341 to WIT-17347

relinquish interesting work and work which they had been trained to do. The purpose of centralisation and the principle behind it is that the overall delivery of cancer services will be improved if expertise is centralised. Centralisation allows for the development of skills in an area. Allowing the continuation of small numbers of procedures regionally raises risks to patient safety, as surgeons who do not regularly perform procedures risk becoming de-skilled and centralisation is therefore the safer option for patients.

80. Although many surgeons and cancer specialists were not entirely happy with all the recommendations set out in the IOG for Cancer, Mr O'Brien was clearly unhappy with aspects of it.[70] He was reluctant to accept the recommendations to centralise specialist surgery and cancer work in the interest of improving overall standards.

81. Following on from the implementation of the three-team model in 2013 all cystectomies were to be carried out by the Belfast Trust. Mr O'Brien continued to plan to carry out benign cystectomies, arguing that the Department's direction did not apply to benign cystectomies.

82. In his witness statement he said:

> "On another occasion, I was again scheduled to meet both Dr Rankin and Mr Mackle as they had been informed that there remained a patient on my waiting list for elective admission for a simple cystectomy and ileal conduit urinary diversion. Though I cannot recall the patient's name, she was an elderly lady who had had two or more unsuccessful attempts by gynaecologists to manage her severe urinary incontinence by surgery. She had then been referred to me for consideration of a urinary diversion as she remained totally incontinent of urine. I agreed and considered that it would be reasonable to remove her bladder at the time of urinary diversion. I was instructed by Dr Rankin and Mr Mackle that I would not be permitted to undertake her

[70] See Mr O'Brien's letters at TRU-281859 to TRU-281864 to Ms McNicholl dated 20/12/2008 and his letter to Dr Rankin dated 27/9/2010 at TRU-281865 to TRU-281867

surgery, as simple cystectomies had been centralised to Belfast. I asked whether I would be permitted to perform an ileal conduit urinary diversion for her, without cystectomy. Both were happy for me to do so. I found it remarkable that I was not permitted to perform a simple cystectomy, but that there was no concern whatsoever in performing an ileal conduit urinary diversion, without simple cystectomy, the reconstructive component of the operation accompanied by greater risk than simple cystectomy."[71]

83. Mr O'Brien told the Inquiry that he had no issue with the transfer of benign cystectomies to the Belfast Trust and that he was not reluctant to do so. He said that his only objection to doing so was that there ought to have been a letter notifying himself and Mr Young saying that the Belfast Trust was ready to accept patients and had the capacity to carry them out. He said that he and Mr Young had requested a transition period to prepare patients for transfer.[72]

84. He did, however, write letters to colleagues and patients in a manner that was regarded as unprofessional, because it was undermining to the consultant involved and risked causing distress to patients.

85. When Mr Wolfe questioned him about his behaviour in writing letters to the GP of a patient whose transfer was mandated, to the patient, and to the surgeon in the Belfast Trust who was to perform the cystectomy, Mr O'Brien appeared to accept that his actions were inappropriate but then deflected from same:

"Q. The premise of my question was these were inappropriate correspondence on the part of you.
A. Well -- yes.
Q. You should not have been, as Mr. Hagan would have it, writing to the patients in the way that you were, suggesting management decisions, or the appropriateness of management decisions that he may not be able to deliver, and putting him under pressure using words like "dread" to

71 WIT-82497 to WIT-82498, paragraph 277
72 TRA-12438

make a decision consonant with your own management decision for the patient?

A. Yes.

Q. Inappropriate he thought.

A. Yeah, I understand how he came to that conclusion and felt in that way. And when you look at it retrospectively in the cold light of day, it would -- I can understand how anybody would agree with that. However, the context is equally important. Because if we had had that one month notice period in order to transfer people in an orderly fashion, such communications would not have been made to GP, to Chris Hagan, or to any patient, and I cannot emphasise that adequately. Whether that excuses, in your view, the language that was used. But patients were dreading the prospect that they would have their surgery or management deferred by this precipitous decision that took place on a Wednesday.

Q. Yes. We know from the materials that have been made available to the Inquiry, and I'm sure you've seen it and indeed remember it, your actions in writing these letters in that way was the subject of criticism from Dr. Rankin.

A. Mm-hmm.

Q. The correspondence AOB-00191 was sent to you on the 27th September 2010, and it is expressed in terms of being great concern that you've indicated to a patient in advance of a care pathway being agreed your preferred management of the case.

"I believe this puts inappropriate pressure on the receiving team and is regrettable."

That's something, looking back on it now you see the sense of, that being a fair comment, albeit that you were working in, you would call, extreme circumstances?

A. Yeah. It is most regrettable that this transfer at that time took place in the manner in which it did.

Q. Yes?

A. And I appreciate that the Inquiry is also familiar with the other aspects of the communications between Mr. Hagan and Dr. Diane Corrigan

subsequently about their lack of preparedness for such a precipitous decision. So I think actually that there was a lot of exasperation, and frustration, and concern for patients at that time that led to that kind of language being used."[73]

86. GMP states that in providing good clinical care a clinician is mandated to refer a patient to another suitably qualified practitioner when this serves their needs.[74] The Inquiry considers that this incident was indicative of a general reluctance on the part of Mr O'Brien to seek subspecialist advice or refer to other specialists unless he felt it necessary. We do consider that he was reluctant to accept the recommendations to centralise specialist surgery and cancer work in the interests of improving overall standards. By not referring on he was placing himself in a vulnerable position, as being seen to be reluctant to do so left him open to an accusation that he was practicing outside the limits of his personal expertise.

87. Moreover, Mr O'Brien's response to Inquiry Counsel demonstrates an attitude that the Inquiry saw repeatedly in evidence.[75] Mr O'Brien is seldom able to accept responsibility for actions he took that had adverse consequences. In this instance he deflects from his action in writing inappropriately by saying that others had concerns about the preparedness of the Belfast Trust to take on cases.

88. Several of the nine SAIs also disclosed a lack of insight on the part of Mr O'Brien. He provided the Inquiry with detailed responses to the cases.[76] He told us he had regrets about his treatment in two cases – Patient 9 and Patient 3. More is said about this lack of insight later in this chapter.

89. In addition, the Inquiry was told by one witness[77] that Mr O'Brien had performed a benign cystectomy for recurrent urinary tract infections. Mr O'Brien disputes that an operation took place as alleged and the Trust could not locate any

73 TRA-12442, line 25 to TRA-12444, line 21
74 See GMP Domain 1 paragraph 15c at INQ-30875
75 TRA-12442 to TRA-12444
76 AOB-82713 to AOB-82720 regarding Patient 9
77 See witness statement of Mr Hagan at WIT-98846 and the MHPS chapter

documents relating to such a case. The Inquiry cannot comment on the accuracy or otherwise of the recollection, nor do our Terms of Reference require us to do so. The Drake review of the benign cystectomies was inconclusive. The removal of the bladder for a non-cancerous condition is a very significant issue and, in governance terms, one would expect evidence of discussion with a wide group of colleagues with expertise in this area if this procedure were to be carried out. That would be good practice. There is no evidence that this kind of wide discussion took place for any procedure such as this. For the Inquiry, lack of such evidence raises the question of whether there were sufficient team discussions taking place within the urology team generally.

Triage

90. This Report discusses the issue of Triage in more detail elsewhere, in particular in the consideration of Term (e) of our ToR relating to the Trust's use of MHPS and in the chapter relating to what we heard from patients.

91. Triage is a critical process in healthcare, involving the prioritisation of patient cases based on urgency and severity to ensure timely and appropriate care. At its most basic level triage involves the assessment of the urgency of a patient's need for treatment. Typically, triage involves evaluating the severity of each case, categorising them into different levels of priority, and allocating resources accordingly. This process ensures that the most critical issues are addressed promptly while less urgent matters are handled later. Once the referral letter is triaged patients are placed on waiting lists in accordance with the categorisation: red flag, urgent or routine.

92. In the urology service, as with other services, triage takes place when a referral letter from a patient's GP is received. Today most letters are submitted electronically. The letter may be directed to a named consultant or to the service generally. Letters were allocated to the UoW to triage.

93. The Inquiry acknowledges that in today's healthcare service and in particular in Northern Ireland waiting lists continue to increase, resulting in all urgent and routine cases waiting for significantly longer for care than is desirable.

94. Ideally, as Mr Haynes pointed out in his evidence to the Inquiry, the electronic referral process would ensure that the GP completed a check list that ensured the appropriate categorisation was given to an individual case and thereby avoid the need for triage:

> "In a process like referral in to Secondary Care, any process works best if the first decision is likely to be right almost all the time. The best process would be a process, as I mentioned earlier as an example, if you are over the age of 45 and you've got blood that you can see in the urine, there shouldn't be any mechanism by which you can be referred on anything other than a Red Flag basis. Using technology available to us and electronic referral forms, then the ideal situation would be that that actually the referral category is right and I don't need to double-check it. What Triage is doing, or one of the things Triage is doing is it's utilising Clinical time in a Service that hasn't got enough Clinical time to check that the referral category is right, rather than using technology and mandated fields to make sure that it's right at the outset. That is where I say I think Triage is nonsense. If we are having to check and you are getting a significant percentage are referred at the wrong category, and that carries a patient risk at the back of it, then surely a better process is one that ensures that it isn't wrong."[78]

95. Nonetheless the systems are not ideal and patients rely on the consultants in the Trust's urology service to triage referrals. Moreover, there was a failure to agree to a precise methodology for triage within the urology team.

96. The urologists triage while carrying out their duties as UoW. Each consultant, when they spoke to us, described how they discharged this obligation.

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78 TRA-00925, line 15 to TRA-00926, line 8

97. Mr Young emphasised to the Inquiry that triage was essential and that routine and urgent referrals are often the most important to review. The Inquiry agrees. He liked to clear his administration at least once a week. This included triaging referral letters.[79]

98. What is clear from the evidence is that over many years Mr O'Brien did not perform triage in the timescale required and only made attempts to try to catch up when reminded of the urgency by managers. The issue was longstanding and was raised with Mr O'Brien repeatedly over more than a decade. Matters would improve and then he would fall behind again.

99. Mr O'Brien admits that he did not complete his triage as UoW, claiming that there was not enough time to do so.[80] Mr O'Brien's failure to triage impacted patient care and led to criticisms of his approach, which was described as inefficient. The Inquiry accepts that Mr O'Brien's ability to triage was subject to workload pressure, however, his colleagues, who faced the same difficulty of competing challenges in their work, implemented measures to address these competing priorities to ensure the task of triage was completed in a timely manner. The pressures of the service were not unique to Mr O'Brien, yet the failure to Triage was.

100. Mr Haynes, for example, told the Inquiry how he was able to speed up triage by using electronic systems:

> "I had a group of standard letters that I generated, so it didn't take me long to generate a letter to the patient saying you are going to have a scan. My Triage was electronic, or it is electronic now. I would have already been in the Electronic Care Record, I would have put on the request for the scan and I'd

79 TRA-09739
80 TRA-12248, lines 12-21

have done the Triage. It would have taken a few minutes longer than just doing the Triage, but it wouldn't have taken the time of a 20-minute consultation."[81]

101. The Inquiry is of the view that Mr O'Brien's refusal to adapt his practices effectively amounted to either a failure to recognise or a refusal to acknowledge the patient safety risk to the patients who were not triaged. This risk was initially demonstrated in the case of Patient 10 and then with the combined five SAIs that followed.

102. Further, the refusal to perform this duty was a unilateral prioritisation of other things that needed to be done by Mr O'Brien. It was taken without any discussion with other team members; indeed, they were shocked to discover the extent of untriaged cases when the MHPS investigation commenced and they were asked to assist with the backlog. Moreover, he left undone triage for Mr O'Donoghue, who followed him as UoW, without seeking his consent to increase this workload.[82] Mr O'Brien was not specifically asked whether he had left triage for Mr O'Donoghue but accepts he did not complete his triage during his time as UoW. This failure to prioritise patient safety is not in the spirit of GMP. It is also outside what might be considered as normal custom and practice in a hospital. Mr Haynes told us that:

"I think all members of the Urology team would have expressed at various points that there was essentially too much work to do, and Triage was part of that. As you say, there were points in time where it had been identified previously where he'd not been doing Triage, and that had been found rather than raised as I'm not doing this, is my understanding. I don't think it was so much a, we know he's an issue that he can't do it, it's every one of us has an issue that we have got a lot of work. I think what was challenging was my colleagues knew, for instance, how I did Triage, which was trying to be as efficient as possible. Mr. O'Brien had taken a view that he would phone all of these patients, which inevitably meant that the patients, when they got phoned,

81 TRA-00859, lines 6-15
82 TRA-08573; TRA-08578 to TRA-08584

got a very good service because they got essentially a consultation, but it also inevitably took even more time than was required, and so he'd made a choice to do it in a way that took longer than was necessary, and he wasn't willing to change the way that he did it to take less time and, therefore, enable him to keep on top of it."[83]

While I had a view personally about whether alternative systems could be adopted that made the requirement for this less of an issue, I didn't abandon it as a duty to carry it out, and I carried it out. I also, as I described, adopted strategies to streamline patients' contact with the Department by a form of Advance Triage that was as efficient in use of my time as I could make it."[84]

103. The Inquiry asked many of the clinicians about their attitude to triage and how each of them approached the task.

104. Mr Young when responding to Dr Swart's questioning regarding triage said:

"The vast majority of us knew what -- had interpreted what triage was involving. And Mr. O'Brien was making it too complex in that it was taking too long."[85]

105. Mr Glackin described a structured approach to his UoW duties. He emphasised the importance of triage and noted that failure to triage appropriately should result in an IR1 (incident report).[86]

106. Mr O' Donoghue told the Inquiry how he completed triage daily, often late into the evening after other clinical duties.[87]

83 TRA-00860, line 21 to TRA-00861, line 12
84 TRA-00926, line 23 to TRA-00927, line 1
85 TRA-09796, lines 5-8
86 TRA-08168
87 TRA-09816

> "Triaging was something that didn't need to be done immediately and so it was dealt with when I had time to do it. So I didn't sort of cut corners in other activities or do less in the other activities at the expense of triage."[88]

Mr Akhtar also sometimes stayed late to complete his triage in the same week.[89] Mr Connolly dealt with his triage during theatre downtime or at the end of the day, staying late if necessary to complete it.[90] The Inquiry noted that all the consultants had difficult decisions to make when it came to prioritising different aspects of their work. It seems that other consultants prioritised triage, whereas Mr O'Brien who also often stayed late, completed other duties but did not succeed in prioritising triage to the same extent.

107. Mr Suresh's evidence was to the effect that when he was working in the Trust, there was a departmental policy agreed at meetings to do advanced triaging which involved categorising referrals and ordering investigations.[91] Mr Tyson indicated that he undertook advanced triage during his on-call week, reviewing both electronic and paper referrals, ensuring that all were done by the end of the week.[92]

108. Mr Robin Brown told the Inquiry that triage was a clinical responsibility.[93]

109. There was a failure to agree a precise methodology for triage within the urology team as a whole. Mr O'Brien favoured only doing 'advanced' triage which was very time-consuming and effectively became a remote consultation. His colleagues had a more pragmatic approach. The evidence from colleagues is that it was difficult to agree a team-based approach with Mr O'Brien as he was not amenable to challenge, even though in general he was affable in his day-to-day interactions. This was a failure to work collaboratively. Mr O'Brien in his response to criticism about his method of triaging rejected the notion that he should just

88 TRA-09816, lines 18-22
89 TRA-08415, line 29 to TRA-08416, line 13
90 TRA-09500, line 9 to TRA-09501, line 28
91 TRA-08603, line 3 to TRA-08605, line 13
92 TRA-08897, line 4-27
93 TRA-09195, lines 17-24

follow what his colleagues did. Instead, he considered that the Trust should provide him with a clear, agreed policy of what the Trust expected. He told us:

> "The fundamental issue with regard to triage was for myself, with my colleagues sitting down with, for example, the Medical Director and the Director of Acute Services, to work out exactly what it was that was required of us. That's what I wanted. That's what I asked for. That's what did not happen." [94]

110. The Inquiry is of the view that even if there were an agreed Trust policy, this is unlikely to have remedied the problem of Mr O'Brien's failure to triage. We noted evidence of Mr O'Brien not following Trust policies when he disagreed with them, even when mandated to do so.[95]

111. Mr Haynes summed up this attitude:

> "I mean, essentially you are presented with a Clinician who, the reason the SAIs had happened is because he had not been able to do the Triage of a significant number of referrals, and had not done it and had not alerted anyone that he hadn't done it. What he's saying there, in my interpretation, is, even though that's the case, I'm not willing to change the way I do it to try and meet the time scales the way that my colleagues do until someone tells me exactly what's expected of me."[96]

112. Mr O'Brien was not alone in his view of the need for a Trust policy telling them how to triage. Mr Glackin told us:

> "Mr. Haynes had one particular view, that we were responsible for sorting this out ourselves and that "we were the Trust", I think was the phrase he used. … Mr. O'Brien, Mr. Young and I didn't share Mr. Haynes view. We felt that it was incumbent on the Trust to provide a policy to clearly outline how this activity

94 TRA-12191, lines 16-21
95 Eg: the use of bipolar equipment for resections. See also email correspondence with Dr Wright at: TRU-278868 to TRU-278870
96 TRA-00928, lines 3-11

would be delivered, and we were therefore at variance with Mr. Haynes in that regard."[97]

113. The Inquiry noted that there was a discussion among the consultants at a development day on 24 September 2018. Minutes of the meeting were circulated by Mr Glackin on 27 November 2018.[98] The minute states:

"**Triage of new referrals.**

The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risks for patients on the curent [sic] long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the Urologist of the week."[99]

114. The Inquiry notes that although this discussion occurred at a time when Mr O'Brien was surreptitiously recording meetings that he attended, curiously this discussion, which was obviously important to Mr O'Brien was not recorded. The Inquiry might have found it useful to learn in detail the discussions that took place.

115. Several operational managers were aware that Mr O'Brien had repeated difficulty in completing his triage. The issue was not dealt with effectively despite considerable efforts over the years.

116. The issue was raised, together with other matters, as far back as 2009 in a meeting with then Chief Executive and the Director of Acute Services, Dr Gillian Rankin, when she was newly in post. It was recognised that if the issues

97 TRA-08798, line 26 to TRA-08799, line 6
98 WIT-31007 to WIT-31013; TRU-257526
99 WIT-31008, paragraph 1.2

identified (relating to Mr O'Brien's practice) were not resolved, further supportive intervention would be needed:

> "Action agreed that if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken."[100]

117. The operational managers attempted to highlight the problem and come up with solutions. We heard evidence of what was called the 'default system'[101] within the Trust, whereby untriaged cases were placed on the waiting list in accordance with the categorisation given by the patient's GP. While this stopgap may have ensured that no patient was entirely lost to the system, it was essentially an administrative device. It did not detract from the need for cases to be properly triaged. Moreover, it might be said that it provided a smokescreen for the failure to triage and the need to properly address the failure with the clinician.

118. Governance systems were clearly not sufficiently robust to have the issue appropriately escalated and dealt with through the medical management line. Dr Rankin stated in her S21 response:

> "There was poor professional practice which had been longstanding. It proved to be difficult to get agreement with Mr O'Brien to change this behaviour. When change in his behaviour was agreed, the specific behaviour was not always sustained and he would revert to previous poor practice. An example of this was when Mr O'Brien agreed to triage referrals within the required time standards; it became apparent subsequently that this change in behaviour was not sustained and required regular checking."[102]

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100 See statement of Dr Rankin at WIT-15820, paragraph 28.3, a. iii
101 TRA-05218 to TRA-05219; TRA-07053 to TRA-07054; TRA-07161 to TRA-07182; TRA-07340 to TRA-07347; WIT-96628
102 WIT-15928, paragraph 69.1c

119. She describes how there was a failure to engage fully with the issues coupled with a resistance to change clinical behaviour.[103] There is clearly an element of individual responsibility on the part of the clinician. Consultants are senior employees and are expected to understand the procedures and policies in the hospital in which they work. The GMC emphasises their duty to understand systems of governance.[104]

120. Mr O'Brien failed to understand the Trust's systems of governance and failed to raise his lack of ability to triage as a patient safety issue. When giving oral evidence Mr O'Brien displayed his lack of knowledge of how to raise incidents and use the system to raise safety issues. He described being unsure as to what an IR1 was and joked in evidence he thought it might be an income tax return. This may have been said in jest, however, incident reporting systems are an important part of learning from error, and all doctors have a duty to understand the way these systems are used. Mr O'Brien seemed essentially disinterested in this, regarding it as unimportant compared to his core work.[105]

121. His failure to triage was something he could have raised himself had he understood the systems of governance and had he realised that his failure to triage was in effect his own risk-based choice. He seemed to think that other patient safety risks presented a greater problem than his failure to triage and he was not prepared to change his way of working to align with his colleagues. He should have openly drawn attention to this. Telling colleagues that he found it 'impossible' to do was insufficient.[106]

122. Equally, however, there was a failure to use the available methods of addressing this as Dr Rankin reflected:

> "On reflection, this type of behaviour should have been recognised for what it was, and identified and discussed by me with SMT colleagues when more

103 WIT-15930
104 See GMP Domain 2 at INQ-30878
105 TRA-04735, line 27 to TRA-04736, line 8
106 See MHPS chapter

formal action could have been considered. Formal action could have been considered with the Medical Director and the Director of HR and Organisational Development. In conclusion, I did not fully utilise the arrangements which were available at the time in order to address the continuing clinical behaviour which did not meet the standards required."[107]

123. Ms Corrigan as HOS often tried to address the issue herself rather than escalating it. At other times, she escalated the issue, often verbally, to the Lead Clinician, CD, Associate Medical Director, Assistant Director for Surgery and Elective Care or Director of Acute Services.[108] A number of witnesses recognised, with hindsight, that more formal escalation of issues by members of the management hierarchy would have been beneficial.[109]

124. The failure to ensure timely triage is discussed fully in the MHPS and Governance chapters. Medical and operational managers failed to identify and escalate this as a substantial risk to patient safety. This indicates a failure of governance systems in urology and the Acute Directorate but also more widely in the Trust.

125. At the time of the MHPS investigation Mr O'Brien's colleagues were shocked to learn of the extent of the untriaged cases. Trust governance systems did not highlight this issue as effectively as they should. Regular reports on triage delays should have been brought to the team's attention as part of normal business and failures to improve should have been escalated as appropriate.

126. Since the SAIs the Trust has moved to change how triage is monitored within the specialty. Mr Haynes told the Inquiry that there is now a monitoring and escalation process in place which should pick up outlying behaviour regarding triage as well as to the actioning of results and dictation.[110] Mr Haynes told us:

107 WIT-15933, paragraph 72.4. See more on this at paragraph 368 of the Governance chapter
108 WIT-26270, paragraph 55
109 See evidence of Ms Corrigan at WIT-26302, paragraph 68.2a.; Ms Forde at WIT-61203, paragraph 42.4, where she refers to the lack of action regarding availability of notes; Mr Carroll at TRA-03529, line 12 to TRA-03530, line 12
110 TRA-11485

> "We also have an in-person interface meeting where myself, the head of service, our manager for our admin and support team, and our Cancer Services manager meet on a monthly basis and run through the performance across the team looking at triage, looking at dictations, looking at results management, and if any other things need to be brought up."[111]

127. This development is to be welcomed, and it is to be hoped that all cases that come into the Service will be triaged expeditiously so that no other patient can miss being upgraded where this is necessary. The Inquiry understands that the introduction of the region's electronic patient record system "encompass" is being used by the Trust to deliver improved triage processes.

Delay to diagnosis

128. There was evidence before the Inquiry of cases where there was a delay in patients receiving a cancer diagnosis.[112] Any delay to diagnosis of a patient with cancer is undesirable and there are clear clinical consequences. Any harm due to a delay is related to the biology of the cancer in question together with the age and fitness of the patient. Biologically more active cancers will be more likely to spread either locally into lymph nodes or adjacent structures or metastasise via the blood stream. Some cancers are very slow growing and may never in fact be a threat to the individual but a delay in diagnosis is never easy to explain to the patient and their relatives. The longer the delay to diagnosis of a cancer the more likely it is to be more advanced and therefore less curable.

129. Aside from the cases where diagnosis was delayed because they were not triaged either in time or at all, the Inquiry learned from the nine SAIs reviewed by Dr Dermot Hughes and Mr Hugh Gilbert of delay in diagnosis due to excessive waiting list times; for example Patient 2 with an abnormal testis who waited seven months from referral by his GP to diagnosis and Patient 8 who had lower urinary

111 TRA-11485, lines 14-20
112 See findings of SAI team at DOH-00122 which found that five of the nine patients looked at experienced significant delay in diagnosis of their cancer

symptoms waited seven years for a prostate operation by which time an incidental cancer was diagnosed. Within the nine cases, cancer diagnoses were also delayed by the failure to look at results as soon as they became available. Patient 8 is an example of this as he was not recalled for eight months following his transurethral resection of prostate (TURP) operation to be told his prostate pathology contained cancer. Patient 5, who was recovering from a radical nephrectomy for kidney cancer had a surveillance CT scan showing probable metastatic prostate cancer but was not recalled for ten months to be told his diagnosis. Inquorate MDMs were another cause of delay according to the SAI review. It was their view that Patient 3's invasive penile cancer ought to have been referred immediately to a specialist penile MDM. Patient 2 with testicular cancer should have been immediately referred to medical oncology. Patient 4 with high grade prostate cancer should have had immediate referral to clinical oncology.[113] Separate from those nine SAI cases, Patient 92's unactioned CT report led to a three month delay in the diagnosis of kidney cancer.[114]

130. Failure to look at histopathology[115] and radiology[116] reports in a systematic way evidently risks causing harm to patients. Urology is a heavy user of radiology for investigation of symptoms, staging and surveillance of patients with both benign and malignant disease. There need to be robust mechanisms to report routine satisfactory results and even more importantly to flag up abnormal and worrying results.

131. As with any process there may be faults along the way and for one reason or another the result does not come back to the office or, if it does, there is a clerical or administrative problem leading to no further action being taken. Healthcare Safety Investigations regularly highlight failures in care that can result if:

113 See Overarching Report at DOH-00112 to DOH-00133
114 WIT-54400
115 Histopathology is the science of pathological examination of tissue specimens removed by a surgeon. Specimens removed at surgery or biopsies are always examined and reports sent back for review by the operating surgeon.
116 Any imaging modality from the simplest ultrasound scan to the most sophisticated radiological intervention such as a kidney mass biopsy.

- reports on abnormal findings are not notified to users;
- referrers do not review the reports; and
- systems that are supposed to highlight reports that have not been read are not effective.

Accordingly, most Trusts have asked departments to put in systems to deal with this problem.

132. As a safety net most radiology departments have a system of flagging 'significant abnormality alerts' either to the referring clinician or to a responsible clerical person within the same department or better still, both.

133. Information made available to the Inquiry indicates three cases where there was a significant shortcoming in the recognition of and response to abnormal radiology reports thereby putting patients at risk and leading to SAIs.[117] In the three cases a CT report was not responded to, with the resulting delay to diagnosis of an unexpected new cancer, illustrating a failure of both the standard and safety-net processes.

134. Analysis of the three cases shows that there was a problem with the handling and response to radiology reports by Mr O'Brien himself, his secretary and the cancer tracking department. In all cases the SAI team found the reports were communicated appropriately to Mr O'Brien and his secretary but not to Cancer Services.

135. The Inquiry learned that there was no failsafe mechanism whereby suspicious results were escalated to the secretary, Mr O'Brien and the MDM coordinator and although there was a radiology alert mechanism this was only available to radiologists within the Trust.

117 Patient 92, Patient 5 and Patient 7

136. It is the responsibility of the doctor requesting tests and investigations to look at the results of those tests. There are also ways that radiology departments alert doctors when results reach certain criteria and are 'unexpected'. This is an area where there can be controversy unless clear agreements have been made to define what is meant by 'unexpected' and exactly how this would be alerted.

137. The Inquiry recognises that most consultants do have some system of looking at results. No system is completely foolproof, for example junior doctors may request tests and then move on, or tests could have been ordered by locum doctors, or there may be gaps in cover due to staff sickness. Nonetheless it is not impossible to devise systems to mitigate such issues and notification of the availability of results can be done more easily with electronic systems.

138. All reports should be seen by the referring clinician and results usually generate a letter. If results are abnormal, either a call or an arrangement to see the patient urgently in clinic would be appropriate responses. If the result is satisfactory and the patient is due for clinical review in outpatients soon, no action needs to be taken and the report, if paper, can be signed and filed.

139. Like most consultants, Mr O'Brien requested many scans and tests on his patients. It was his practice to bring patients back to a clinic appointment to review the test results and the patient. He did not feel he needed to review test results until just before clinic visits and, even though notes with results were left out for him, he did not systematically look and act on those results. This came to light at the time of an SAI in 2009. Mr Eamon Mackle told the Inquiry:

> "a "never event" occurred whereby a swab was post-operatively left in a patient and was only discovered a year later when the patient was admitted as an emergency. A CT scan had been reported as abnormal three months later, but an investigation revealed that Aidan O'Brien had a policy of not reviewing results until patients attended out-patients. Aidan O'Brien raised multiple objections when it was suggested that he should be reviewing all results therefore an instruction was issued to all consultants informing that it was their

responsibility to review all the results of investigations on their patients once they are available."[118]

140. It would appear that the extent of the response to this was that Ms Heather Trouton checked the practice in other specialties. Mr Mackle's recollection was that most consultants reviewed results regularly, but they could not be certain that they all did:

> "an instruction was then issued to all the consultants in the Directorate reminding / informing them that it was their responsibility to review the results of investigations on their patients once they are available. Secretaries were informed that results of investigations were not to be filed in the chart unless they had been reviewed and signed / initialled by a consultant."[119]

141. Mr O'Brien's response to the mandate to look at results was to draft and send a lengthy email asking questions and listing problems, essentially objecting to what is considered good medical practice.[120] This email was copied by Mr Mackle to Dr Rankin in 2011. Although Dr Rankin asked Mrs Trouton by email to discuss the matter with the urology surgeons,[121] Mr O'Brien's email was not responded to. Mrs Trouton may have spoken to the surgeons, but it would appear it was left to operational management to address when medical management ought to have been involved. This was a failure of management and leadership and more ought to have been done to address a serious patient safety issue.

142. This email should have resulted in a face-to-face meeting with Mr O'Brien, his medical line management and the Acute Director, Dr Rankin at which his concerns could have been aired. However, his duties in this regard had already been made clear. In the email Mr O'Brien makes some valid points about difficulties in capturing all investigations which may have been requested by others. The Inquiry is however of the view that he should have been instructed to

118 WIT-11744 to WIT-11745, paragraph 24
119 WIT-11819, paragraph 225
120 AOB-00282; TRU-276804 to TRU-276805
121 TRU-276804

comply with the direction received from Ms Corrigan and to confirm in writing that he would at least make every effort to do so. He ought to have been assisted to set up a system that he could work with. He should have been told clearly in writing that waiting until the next outpatient review was not acceptable or safe. In the event of this approach being unsuccessful or difficult, the matter could have been escalated to the MD for advice and guidance. The Inquiry considers this as another missed opportunity to address a very serious issue.

143. There is no doubt Mr O'Brien did not systematically look at the results of tests he had requested, and his actions clearly resulted in harm to patients. His actions or lack of actions were contrary to all guidance in this area. This guidance was found in documents produced by the Royal College of Radiologists and the Academy of Medical Royal Colleges (AoMRC).[122] The AoMRC issued guidance in October 2022 entitled '*Alerts and notification of imaging reports*' which included the preceding guidance from the Royal College of Radiologists. This guidance was published in successive years following a significant safety alert issued in 2008 by the National Patient Safety Agency (NPSA). It was extant in the years leading up to the Inquiry. The guidance published in 2022 expanded on but did not amend the earlier guidance. The following is listed as a guiding principle:

> "Prompt review, acknowledgement and action on all imaging reports by the referrers"

and takes this further to state the need for:

> "A system to facilitate identification and action of reports which have not been read, acknowledged and acted upon."[123]

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122 See: The Royal College of Radiologists: Alerts and notification of imaging reports, Recommendations (2022) at: https://www.rcr.ac.uk/our-services/all-our-publications/clinical-radiology-publications/recommendations-on-alerts-and-notification-of-imaging-reports/, which highlights responsibility of the referrer which is assumed in all other documents

123 The Royal College of Radiologists: Alerts and notification of imaging reports, Recommendations (2022), page 7. See Footnote #116

This means that doctors who request investigations have a duty to look at them and take any necessary action and the Trust must support systems that help keep track of the reports issued and record whether or not they have been examined by the referring doctor.

144. That document references The European Society of Radiology guidelines for the communication of urgent and unexpected findings which highlighted that good communication helps to improve patient safety and that referrers should be aware of their responsibility to read and act on radiological reports. It encouraged 'enhanced communication' for emergencies and unexpected findings. It pointed out that a concern was that referrers relying on alert mechanisms would assume that reports are normal or have no significant findings. The report also highlighted a concern that:

> "the responsibility for ensuring that imaging reports are acted upon and even legal responsibility will transfer to radiologists, even though they have only limited information about the patient at the time of reporting."[124]

The various documents and guidance in this area aim to support a collaborative approach from the referring clinician, the radiology department and the organisation – in this case the Trust.

145. It should also be recognised that all alert mechanisms take additional time, effort and resources, so there are associated productivity costs. This relates to the controversy issues noted above.[125]

146. This subject was also examined by the Regulation and Quality Improvement Authority (RQIA) who sought and obtained assurances from hospitals including the Trust, regarding the communication of unexpected findings and noted that:

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124 The Royal College of Radiologists: Alerts and notification of imaging reports, Recommendations (2022), page 9. See Footnote #116

125 Paragraphs 136 and 138

"This will not replace the essential requirement for each referrer to be responsible for reading the result of every investigation they generate but should be aimed at providing a safety net for the highlighting of significant findings."[126]

147. Examples of failure to view results were clearly seen in the cases of Patient 10, Patient 92, Patient 95 and Patient 5. The SAI report in the latter case indicated that the patient had had a CT scan, the result of which was not seen by Mr O'Brien or flagged up to be acted upon by the radiologist or anyone else.

148. Patient 5's daughter's evidence is discussed in the Patients chapter. She spoke at length about the failure to action results in a timely way and, in response to questions from Dr Swart, reflected on what had shocked her most about her father's care was the failure to action the result of his scan over a seven-to-eight-month period.[127] She had been involved in the Task and Finish Group set up by the Trust following the SAIs and was clearly aware of the RQIA recommendations that scans should be disseminated and then followed up quickly by the clinician.[128]

149. As was stated elsewhere in the Patients chapter, there is a responsibility on the clinician to ensure that all results are looked at once available, but there is also a responsibility on a Trust to have systems in place that will ensure, as far as possible, that results are not missed. Not having a sufficiently robust system was a clear governance failing on the part of the Trust.

150. In 2019 the Trust put into practice the DARO, or "Discharge Awaiting Results Outpatients" system whereby patients for whom investigations had been requested would only be allocated outpatient follow-up slots once the results were through and the consultant had seen and acted upon the results.[129] The Inquiry

126 RQIA Report: "An Independent Review of Reporting Arrangements for Radiological Investigations Phase 1 Overview Report, March 2011": INQ-30498 to INQ-30531, at INQ-30505.
127 TRA-01908
128 TRA-01908
129 See evidence of Ms Collette McCaul at WIT-55864

has been told that the Trust now has a system where there is electronic sign-off of results, which is directed to the referrer, and this is referred back to consultants and other requesters of x-rays so that failures in compliance are noted.[130]

151. For patients of Mr O'Brien, the long delays to follow-up appointments compounded the level of risk, as review appointments did not happen as scheduled and he was not looking at all results. Neither Mr O'Brien nor his secretary Mrs Noleen Elliott used the DARO system as it was intended[131] and he did not have another system in place that ensured all results were looked at as soon as they became available. He told the Inquiry in his closing submission that he regretted not reviewing the report of scans in respect of Patients 92 and 95 but that he did not have time to review all results.[132] The Inquiry found this a concerning statement. It is another example of Mr O'Brien trying to deflect from the adverse consequences of his actions, or in this instance inactions.

152. Moreover, the lack of willingness to consider proper methods to prevent harm to patients, given the long waits for follow-up appointments, indicates a serious lack of insight on the part of the Trust. The Trust has improved oversight in this area but during the period that the issues relating to Mr O'Brien's practice occurred there was a failure to ensure that acceptable standards were adhered to.

Delay to outpatient appointments

153. Following GP referral, patients are seen and examined in an outpatient facility prioritised according to urgency as described. Information available to the Inquiry indicates that there were shortcomings in the implementation of timely outpatient appointments which put patients at risk and gave rise to all nine SAI reports.

130 See Mr Haynes at TRA-11466
131 See evidence of Mr Haynes at TRA-00961; Mr O'Brien at TRA-12489, lines 2-29; and SUB-00229, paragraphs 151-152
132 SUB-00230, paragraph 154

154. In practice, an outpatient appointment enables a surgeon to meet with the patient, take a history, examine the patient and perform simple tests to achieve a diagnosis.

155. Review appointments allow previously seen patients to be reviewed and investigations updated and monitored. Historically the Urology Department has significant backlogs of review patients exacerbated by a high new to review ratio of 1:4 compared to the Northern Ireland average of around 1:2.[133]

156. When too many review appointments are given to patients this proportionally reduces the number of new patients who can be seen and increases the waits for those needing essential follow-up appointments. This results in a risk of harming patients at the expense of those who may not actually require a review appointment.

157. Traditionally clinic template times are around 20 minutes for a new patient and 10 minutes for follow-ups. Longer is needed for a new cancer diagnosis consultation, especially if a CNS is not present to take the patient off for further consultation, support and advice.

158. A small proportion of cancer patients present without red-flag symptoms or even no symptoms at all. Accordingly, it is important that all patients have an acceptable waiting time to their appointments.

159. Outpatient capacity and waiting times have been a problem in the Trust's Urology Department for many years and unfortunately this meant that only patients who were categorised 'red flag' and those upgraded to red flag by triage had an opportunity of being seen in a timely fashion. It is common knowledge, and accepted, that performance targets set by the Department are not met either in this specialty or many others across the health service in Northern Ireland. Most patients categorised as routine wait over a year for an appointment. Targets for

133 See WIT-16773, Regional Review of Adult Urology Services at WIT-16765 to WIT-16779

outpatients are published by the Northern Ireland commissioners. Currently the target is that:

> "50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks;"[134]

160. Mr Ronan Carroll told us:

> "By 2016 and becoming responsible for Surgical and Elective Care the performance targets as described in the IEAP and applicable to urology were not being achieved by a significant margin: e.g., the IEAP in 2008 described the performance targets of 9 weeks for outpatients and 13 weeks for inpatient / day case, and 95% for 62 day cancer target and 98% for 31 day cancer target."[135]

He attached a table which shows how the figures worsened in the years 2016, 2019 and 2022 against those targets:[136]

Specialty	Category	IEAP Target	Waiting time as at 1 April 16	Waiting time as at 1 April 19	Waiting time as at 1 April 22
Urology	Outpatients	9 weeks	Red flag = 3.5 wks Urgent = 40 wks Routine = 73 wks	Red flag = 5-7 wks Urgent = 168 wks Routine = 175 wks	Red flag = 11 wks Urgent = 312 wks Routine = 319 wks
Urology	Inpatient/ Daycases	13 weeks	Urgent = 119 wks Routine = 124 wks	Urgent = 249 wks Routine = 277 wks	Urgent = 399 wks Routine = 398 wks

161. The Inquiry noted that patients of the Trust's urology service endured long waits for their outpatient appointments.[137] This included six who had not been triaged but would have been seen in a timely way had the outpatient waiting times not

134 See page 9 of the Department of Health (NI) 2017 Elective Care Plan at: https://www.health-ni.gov.uk/sites/default/files/publications/health/ECP-070217_0.pdf
135 WIT-13100, paragraph 62
136 WIT-13100, paragraph 62
137 See Patient 10 at PAT-000001 to PAT-000009 and the SAIs relating to five other patients untriaged in the same week at PAT-000400 to PAT-000404

been so long.[138] One for whom a reasonable routine triage had been activated[139] but who waited seven months to be seen. Three patients who had already been seen but not yet had a cancer diagnosis established, i.e. a problem with follow-up appointments.[140] Three patients were seemingly lost to follow up.[141]

162. All of these patients ought to have had either new or review category appointments scheduled. Due to the long delays for both, their cancer diagnoses and management were delayed. None of the nine SAI patients seemingly had the benefit of CNS-led follow up[142] as is standard in most urology departments and which would have improved access to care.

163. The Inquiry asked several witnesses what was done to ensure that those patients languishing on waiting lists were not coming to harm.[143] Mr Haynes said in oral evidence:

> "A. It concerned me that we were in a position that we were having to make those choices. As I have outlined in correspondence, it places us in a vulnerable position, we are having to make prioritisation decisions which we do on the basis of the information available and we do to the best of our ability, but inevitably there is a risk of a patient, an individual patient coming to harm as a result of that prioritisation decision.
>
> Q. At one point on 11th October 2019 you wrote to colleagues. The reference is WIT-55757. You wrote to colleagues to say, in essence, if you believe that the treatment of your patient is unreasonably delayed, you should raise a Datix, perhaps to keep themselves right within the system and as some kind of communication or signal, perhaps to the Commissioners that all was not well?

138 Patient 10, Patient 11, Patient 12, Patient 13, Patient 14, Patient 15
139 Patient 2
140 Patient 5, Patient 8, Patient 92
141 Patient 9, Patient 32, Patient 42
142 See below paragraphs 244 to 259
143 TRA-08113, line 13 to TRA-08117, line 20; TRA-08955, line 8 to TRA-08956, line 17; TRA-09166, line 3 to TRA-09168, line 25

A. Yeah, I think the incident reporting system is, if you like, the intelligence-gatherer for the system. I think I've said in my statement that it had almost become normalised for patients to wait a long time for treatment. If, if you like, the wider system is normalised such that we kind of know it, we could almost -- I felt we were in a vulnerable position to not be flagging that patients are coming to harm because they are waiting longer than they should, and so I encouraged to flag that patients are coming to harm because of the waiting times."[144]

164. Dr O'Kane was questioned by Mr Hanbury:

"Q. In the same sort of line, obviously as surgeons we are very worried about patients being on the waiting list for a long time and, obviously, they had come to harm and they are not necessarily seen back in clinic to make sure they are all right. And there are initiatives for potential harm reviews after, say, a certain length of time, say a year or something. Is that something that you brought in or you would like to see happen?

A. I'm not sure whether they have -- I know that I hear mention -- and I haven't thought about this specifically -- I know that I hear mention of patients that they are concerned about as being long waiters that they have checked up on. So that definitely does get discussed. I haven't asked specifically is that done through the CNSs or is that done through other aspects of urology. But I can certainly check that out and see. But I know, certainly, those long waiters are on everybody's mind, particularly -- I mean, the vast majority of what they do at the minute, almost entirely with the exception of stents, I think, is red flag. So a lot of those patients with long-term urology problems are waiting to be seen. And I know that, certainly in recent times, we have gone back -- and I will check whether or not it is specifically urology, but I know for some aspects in surgery we have certainly gone back to patients in writing to check with them that they are still on our waiting lists and that, actually, if there's anything that

144 TRA-00854, line 16 to TRA-00855, line 13

we need to do to engage with them. Again, that came out of the back of recommendations marked RQIA and others in relation to that."[145]

165. In evidence Mr Shane Devlin told us:

"the Trust would have told Commissioners in those Commissioner meetings, and I think the Commissioners fully understood that everyone waiting on a waiting list had the potential to come to harm. Not just Urology. Everyone waiting on a waiting list has the potential to come to harm. The Commissioner also has an X pot of money that the Commissioner choose to commission services, so I think everyone with their eyes open is very clearly aware that when resources do not meet the demands that are in the system, people will come to harm."[146]

166. Ms Aldrina Magwood, who was the Trust's Director of Performance and Reform, told us:

"Mark Haynes had done a piece about do you contact people who have been essentially languishing on the waiting list for a long time, but it was quite morally distressing even for clinicians to do so when you had no solution for how you were going to be able to see them and when.
There was a lot of work done around that sort of things; [sic] that people were recognising the difficulties and the potential harm essentially to people on long waiting lists."[147]

167. It appeared to the Inquiry that no one was able to give a satisfactory answer. More is said about this in the Governance chapter but given the scale of the problem and the exceptionally long delays, we are surprised that the Board did not ask to see evidence that there was some attempt to prioritise patients who were actively deteriorating on the waiting list. There are ways in which this could have been

145 TRA-01586, line 12 to TRA-01587, line 14
146 TRA-01725, lines 3-13
147 TRA-06067, lines 8-18

achieved, for example by contacting patients to ask about symptoms or by providing a quick method for GPs to indicate deterioration. While it is clear that individual clinicians did raise issues about the service, the Inquiry would have expected the clinicians, ideally as a team, to make more fuss using specific examples of actual patient harm to emphasise how dangerous this situation is for patients. We would have expected them to propose solutions and ways of assessing potential harm to patients on waiting lists, escalating to the Board if necessary.

168. Although this is a common problem in hospitals and in all medical practices, the lack of willingness to consider proper methods to prevent harm to patients, given the long waits for initial appointments, surgery and follow ups, indicates a serious lack of insight. Our impression is that the situation has become almost normalised. The Trust has improved oversight in this area but when waiting lists are so long there must be a system in place to reprioritise cases to try to ensure that those whose condition is worsening can be moved up the lists. Given that this is not unique to the urology service or the Trust, regional guidance could be of assistance.

Management of surgical waiting lists

169. Surgical waiting lists are the method whereby surgeons and their clerical colleagues run their practice according to the urgency of the case in question. Relative priorities make this a challenging task especially when demand is high and capacity restricted. This was certainly the case in the Trust. From information available to the Inquiry there were significant shortcomings in the implementation of waiting lists placing patients at risk and giving rise to SAIs and complaints.[148]

170. Generally, surgeons have fixed and limited weekly sessions when they have access to operating theatres. These may be main theatres where major surgeries happen, day surgery with general anaesthesia or endoscopy (local anaesthesia) lists. The capacity for performing procedures is limited by these factors plus the

148 For example: Patients 4, 8, 16 and 84

complexity of surgery and anaesthesia. Emergencies are the exception where there is an emergency theatre which runs 24/7, but this is available to all specialties in a first come/first served manner. A waiting list is the process of running the service for the urology team.

171. Waiting lists are scheduled by both surgeons and clerical staff combined. Clinical priority is the overarching guide but if cases can be done in day surgery safely, they should be, in order to optimise efficiency and minimise bed usage. There are targets for elective surgery published by the commissioners but the waits historically have been unduly long, especially in the Urology Department.

172. When surgery is scheduled, there are various categories which assist planning, these are: emergency, urgent cancer, urgent, routine and planned. Examples of these in the urology service are as follows:

- Emergency, a patient admitted with flank pain and CT shows a large stone obstructing a kidney which is unlikely to move. This patient should be listed for surgery within 24 hours to disobstruct the kidney.
- Urgent cancer (Red Flag), a patient with a large kidney mass which is highly likely to be a cancer scheduled for nephrectomy.
- Urgent, a patient with urinary retention with a catheter in situ awaiting a TURP to relieve his symptoms or a patient with a ureteric stone and stent in situ awaiting ureteroscopy and laser.
- Routine, a patient with troublesome symptoms for which elective surgery is judged to be of benefit.
- Planned, a procedure which needs to be done at a certain time interval, eg: stent changes are a frequent source of difficulty and should be scheduled in advance at the time the original stent is put in.

173. The Urology Department in the Trust had historic problems with surgical waiting times due to the demand/capacity gap and the limited theatre time available. Analysis of waiting times between specialties in 2018 showed urology had the

longest waiting times,[149] yet the Inquiry saw little evidence of managerial action to rectify this. The Inquiry recognises the difficulties the Trust had with trying to allocate theatre time and the competition in the Acute Directorate for same, where each service sought more of a limited resource, nonetheless we are of the view that more ought to have been done to address the clear imbalance in this specialty. Mr Carroll, Assistant Director of Surgery, told the Inquiry that, by April 2019, waiting times had increased to 249 weeks for urgent cases and 277 weeks for routine cases. The operational management team dealt with this by the following responses:

- monitoring;
- adding to the risk register;
- discussion at the monthly performance meetings;
- providing in-house 'additionality' (extra funded sessions usually at weekends);
- engagement with the independent sector which would also depend on additional funding; and
- waiting times were also discussed at meetings between the Trust and HSCB.[150]

No additional theatre sessions were provided although for a period three session operating days were trialed but discontinued due to staffing issues. It is encouraging to note the new regional approach to certain elective surgeries that is now being taken.[151]

174. The difficulties impacted on the care of patients brought to the Inquiry's attention including:
    - One patient with urinary retention, who was catheterised and uncomfortable, waited five months for a TURP.[152]

149 WIT-82422
150 WIT-13101, paragraph 63
151 WIT-13103, paragraph 70; Eg: using Lagan Valley Hospital, see TRA-08102, lines 18-28
152 Patient 4

- One patient who had urinary symptoms and endured a wait of seven years before his admission for transurethral prostatectomy.[153]
- Two patients with ureteric double J stents in situ, both of whom waited between six and eight months longer than planned for their definitive procedures and in both of whom resultant septic complications ensued. These two cases illustrated the absence of waiting list office management for planning scheduled cases.[154]

175. The Inquiry considered the specific issue of stents that had been highlighted by a number of SAIs over a period of years. It was clear that there was no mechanism agreed whereby stented patients were recalled for removal. In an exchange with Mr Hanbury, Mr Carroll tacitly admitted that there was no waiting list support and no mechanism for recalling scheduled stent cases. If there was a problem it was up to the consultants not the admin staff to sort it out.[155] There are two distinct clinical scenarios: firstly, patients who need a stent permanently should not be on a waiting list as such, they need to have their stent exchange procedure at a certain time interval (normally six monthly) otherwise the stent is susceptible to encrustation and infection; secondly, stent removal combined with a ureteroscopy for obstructing ureteric stone should be arranged within one to two months of the original emergency procedure and should therefore be scheduled. In most, if not all, urology departments this task is dealt with by the waiting list office.

176. In oral evidence Mr Haynes told the Inquiry how waiting list management has since changed:

> "if we look within Urology, we, as a team, function from a pooled waiting list. While someone may be added to the list under my name, that doesn't mean that they are getting their operation under me. They will get their operation when they come to the top of the waiting list by an appropriately trained

153 Patient 8
154 Patients 16 and 84
155 TRA-04614 to TRA-04616

clinician on the next available list. We have a scheduler who plans and schedules our list rather than us having a direct point."[156]

177. Mr O'Brien historically managed his own operating lists having rejected the help of a scheduler as was used by his colleagues. Although more support was put in place to assist Mr O'Brien in around 2010,[157] it would appear that there continued to be difficulties in relation to this issue, as described in evidence to the MHPS investigation in 2017. He apparently allocated dates in accordance with his own view of clinical urgency rather than allocating a priority on the theatre list. This meant there was a risk of failure to prioritise those patients waiting longest for procedures, contrary to Trust policy and effectively is a refusal to participate in open systems to ensure equity of access. Mr Carroll told the MHPS investigation that when he questioned Mr O'Brien regarding not indicating clinical priority on the operating list, he was told "they [his patients] are all urgent".[158] This system was not amenable to oversight. Moreover, the different approach taken by his colleagues meant that it would have been difficult to create combined or pooled lists and difficult to set up fixed systems for time critical procedures, such as delayed or replacement stents. Mr Haynes told us that the current position is:

> "We have a scheduler … So the ability for a consultant to transfer a patient from their private practice into the NHS care and then onto their next operating list is much more limited."[159]

178. More is said in relation to the management of Mr O'Brien's private patients elsewhere in this Report.[160] However, in the case of scheduling private patients for surgery, a process of scheduling was permitted that had the potential to be unfair and was not in accordance with Trust procedures. Although the rest of the consultants in the team managed private patients in private hospitals, Mr O'Brien did not. He added private patients to lists himself when he thought their condition

156 TRA-11379, lines 9-17
157 WIT-15909; TRA-06376
158 WIT-14724, paragraph 24; see also paragraph 157 in Medical Management and Leadership chapter
159 TRA-11379, lines 15-20
160 See paragraphs 355 to 363 of this chapter and further in the MHPS and Governance chapters

merited it, sometimes without these patients having formally been added to the health service waiting list as they should have been.[161] It is the Inquiry's view that stronger leadership ought to have been shown to ensure that the service acted as a team for the benefit of all patients and to ensure equity of access.

179. The Trust provided evidence that the management of waiting lists was part of a Trust-wide improvement plan.[162] This is discussed further in the Governance chapter.

MDM and cancer treatment

180. The NHS National Cancer Plan published in 2000 endorsed MDM discussion for all new cancers to ensure that cancer care delivery is consistent with the best available practice. Northern Ireland practice for urology in the time period of the USI is best seen in the NICaN 2016 Guidelines.[163] NICaN facilitates a number of Clinical Reference Groups (CRGs). There was a specific group for urology. CRGs include a full range of healthcare professionals from all trusts and across the cancer care pathway, (diagnostic and treatment). The groups also include cancer service managers and members who represent the patient and public voice and who have experience of the cancer journey. Groups meet regularly and work collaboratively to deliver the following key core objectives:

- Agree clinical management guidelines and ensure consistency of delivery across all trusts.
- Service planning/delivery.
- Service improvement and redesign.
- Quality monitoring and evaluation.
- Education and workforce and research and development.

161 AOB-15027, where Mr O'Brien disputes this; WIT-53876; WIT-53933; WIT-54106 to WIT-54107; WIT-59603, paragraph 6; WIT-104216 to WIT-104217; TRU-270116
162 See report of internal audit at TRU-320613 to TRU-320627
163 TRU-98371 to TRU-98523

181. Following a diagnosis of cancer all patients are reviewed at an MDM for confirmation of that diagnosis and a panel discussion concerning future treatment.

182. The Inquiry understands that MDMs in Trusts operate generally in a broadly similar way. This structure of MDMs is standardised by NICE and NICaN Guidelines as evidenced by the Peer Review document.[164] Core personnel should be present in two thirds of meetings.[165]

183. The MDM is run by Cancer Services, and the participants should ideally include the following: MDM co-ordinator, a CNS, urologists involved in cancer practice, a radiologist, a pathologist, clinical and medical oncologists. Since some cancers need to be discussed with colleagues in the specialist centres, a video link is arranged for the 'specialist' part of the meeting. Both meetings are an opportunity for shared decision making and bringing expertise for the benefit of the patient. Good team working at the MDM often means the process can be speeded up and unnecessary appointments avoided. A full quorum, personal discussion and enthusiastic involvement in the MDM is therefore critical for the successful treatment of the patient.

184. The MDM recommendation or options are recorded and a follow up appointment made by the co-ordinator for this to be discussed with the patient and their family.

185. Definitive treatment for cancer cases depends on the MDM assessment of stage and grade of tumour, the age and fitness of the patient and a consideration of the patient's wishes. Treatment with curative intent means that there is a reasonable chance of cure, treatment with palliative intent means that there is no chance of cure, but the patient is treated for symptoms with the intention of preserving quality of life. Treatments may be surgery, radiotherapy, chemotherapy, hormones or any combination. An MDM will recommend treatment based on agreed current clinical guidelines.

164 WIT-105536 to WIT-105594
165 WIT-105563; WIT-105570; WIT-105578; WIT-105585

186. Once the stage and grading of the cancer is known, MDM decisions are communicated with the patient at an out-patient appointment where a CNS should be in attendance to give further support. Occasionally, in urology cancers, such as in the case of small renal masses or small volume low grade prostate cancer, there is only a small chance of the cancer growing and causing harm, in which case an observational policy may be recommended, the principle being potential harm of treatment may outweigh the benefit. These latter 'active surveillance' cases may be quite demanding on a patient since knowingly living with a cancer and choosing not to have it treated is seen by many patients as unusual and therefore this group of patients need particularly good support from the CNSs.

187. Obviously, there are some regional and local variations regarding the actual operation of MDMs. An MDT for Urological Cancer at the Trust was formally established in April 2010. Mr Akhtar, Consultant Urologist, was its Lead Clinician and the Chair of its MDM from April 2010 until March 2012. From April 2012 until October 2016 the Lead was Mr O'Brien. Mr Glackin described Mr O'Brien as meticulous in preparing cases for the MDM.[166] We heard from Mr O'Brien himself that preparation for MDMs took a considerable amount of time.[167]

188. With increasing numbers of consultant urologists, the functions of Lead Clinician and of Chair of MDM were separated to enhance active participation in and responsibility for MDM. From August 2014, a rota was established for chairing MDMs by Mr O'Brien and two colleagues, Mr Glackin and Mr Haynes, Mr O'Donoghue was added to the rota in 2015. The Urology MDT Chair at the Trust had a dominant role in being expected to prepare all the cases to be discussed prior to the meeting.[168] This takes significant time, which needs to be found in a busy schedule, as the Inquiry heard from Mr O'Brien and others. Pre-preparation is a technique normally used when the MDT members have agreed

166 TRA-08237, lines 22-26
167 TRA-04726, line 10 to TRA-04727, line 9
168 TRU-99640; TRU-99653 to TRU-99654; WIT-50521

to adopt Streamlining[169] to manage straightforward cases as per agreed protocol, but the Inquiry saw no evidence of the Trust using this process.

189. At most MDMs in departments of the size of the Trust's, patients are discussed by the urologist dealing with that patient. This encourages general discussion, simplifies the meeting and has less of an arduous impact on the Chair. The Trust's Urology MDM takes place at CAH each Thursday afternoon. The meeting takes place in a room with video conferencing facilities, enabling communication by video link to Daisy Hill Hospital, Newry, and with the Specialist MDM in Belfast.[170] It is the policy of the Trust that all MDMs should finish by 5pm at the latest. To achieve this, the number of cases discussed has been capped at 40 per meeting.[171] The Lead Clinician from late 2016 has been Mr Glackin.[172]

190. The cancer peer review specifies that a urology cancer MDT should be made up of the following core members or their cover: urology surgeon (CL); one or more other urologists; clinical oncologist with responsibility for chemotherapy for bladder and prostate cancer; medical oncologist for all testis cancer and advanced and/or metastatic renal, prostate and bladder cancer; one or preferably two radiologists; a histopathologist (an expert in the pathology of cancer); CNSs and an MDT Co-ordinator. These core members are expected to be present at a minimum of two thirds of meetings. In the Trust this standard is articulated in "Urology Cancer MDT Operational Policy."[173] That document includes a table setting out the membership of the MDT as at 01 September 2017.[174]

191. In most MDTs a small proportion of cases need to be discussed with specialist colleagues at the Cancer Centre. In summary these are: cases with early prostate cancer potentially suitable for radical surgery; cases of bladder cancer potentially suitable for radical cystectomy; small renal masses potentially suitable for

169 See "Streamlining Multi-Disciplinary Team Meetings, Guidance for Cancer Alliances". At: https://www.england.nhs.uk/wp-content/uploads/2020/01/multi-disciplinary-team-streamlining-guidance.pdf
170 TRU-99652
171 TRU-98111; TRU-99652
172 WIT-42281; TRU-99729
173 TRU-105282 to TRU-105298
174 TRU-105285 to TRU-105286

nephron sparing surgery or ablation; all testis cancers; and all penile cancer cases. How this part of the meeting, usually known as Specialist or SMDT, is arranged depends on availability of clinicians and videoconferencing.

192. In the Trust it has been agreed by MDT core members that it is the responsibility of urological surgeons to provide a clinical summary regarding each patient to be discussed at MDM for the first time, and an update when patients are to be discussed again at a later juncture in their clinical course. The clinical summaries and updates are to be provided to the MDT Co-Ordinator. They are to be provided in a textual format suitable for uploading unto the Cancer Patient Pathway System (CaPPS) as a permanent record. It is also the responsibility of the MDT Co-Ordinator to request provision of a clinical summary adequate to enable MDM discussion.[175]

193. The SAIs that led to this Inquiry showed that there was a problem with the operation of the MDMs in the Trust's urology specialty. The Overarching Root Cause Analysis (RCA) Final Report[176] identified a number of problems with the MDMs in relation to nine patients of Mr O'Brien.

194. While the findings[177] related to specific patients of Mr O'Brien, some of the findings applied to the operation of the MDM generally. The report found the following issues regarding how the MDM operated:

- While the MDM made appropriate recommendations for most patients, there was no mechanism to check that those recommendations were implemented - this included; further investigations, staging, treatment and appropriate time critical onward referral.
- Most recommendations were compliant with national and regional guidelines, but those recommendations were not always followed. For example, in all five prostate cancer patients looked at in the SAI, the MDM made appropriate

175 TRU-99652
176 DOH-00112 to DOH-00135: Overarching RCA report on the review of an SAI
177 These are set out in full at Section 6 of the above report at DOH-00123 to DOH-00127

recommendations that were not implemented. Further, the NICaN Regional Hormone Therapy Guidelines for Prostate Cancer 2016 were not followed.

- The meetings were not always quorate. The Urology MDM was under resourced and frequently non quorate due to lack of professionals. This was usually due to lack of clinical oncology and medical oncology. Radiology had only one Urology Cancer Specialist Radiologist impacting on attendance but critically meaning there was no independent quality assurance of images by a second radiologist prior to MDM.
- Collation of MDM lists did not include a fail-safe list from histopathology. Such a list would have avoided delayed diagnosis such as was seen in Patient 8.[178]
- The Urology MDM was under resourced for appropriate patient pathway tracking. The Review Team found that patient tracking related only to diagnosis and first treatment (that is 31 and 62 day targets). It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care.
- Safe cancer patient care and pathway tracking is usually delivered by a three-pronged approach of MDT tracking, consultants and their secretaries and Urology Specialist Nurses, in a key worker role.
- The Review found that the nine patients were not referred to Specialist Nurses and contact telephone numbers were not given. This was despite this resource having been increased by the Trust and the Peer Review of 2017 being informed that this resource was available to all. CNSs were not given the opportunity to provide support and discharge duties to the nine patients.
- The MDM tracking system was limited. The consultant/secretary led process was variable and resulted in deficits. The weakness of the latter component was illustrated to the Inquiry by Patient 1's daughter in her oral evidence.[179]
- As patients were not re-discussed at MDM and urology CNSs were not involved in care, the fact that MDM recommendations were not being implemented was unknown to others in the MDM.

178 AOB-03293
179 TRA-00262

- Patients were not aware that the care given varied from Regional Standards and MDM recommendations. They could not have given informed consent to this.

195. Lack of quorum reduces the quality of the panel opinion and means opportunities for radical and alternative treatment options may be overlooked. It also reduces the chance of streamlining the pathway direct to oncology and the lack of oncology support for the SAI cases is especially problematic. Urologists cannot be expected to be experts in clinical and medical oncology as well as their own specialism.

196. Core members should have been present at more than 66% of meetings, the urologists and histopathologists satisfied this as did the CNSs, but the radiologists at 55% and oncologists at 22% or below were woefully lacking. Many urologists would say that having no radiology at an MDM should lead directly to cancellation of the meeting since the radiology is of such diagnostic importance in the majority of cases. It is arguable that the lack of oncology should also make an MDM not quorate.

197. The non-quorate nature of the Trust's MDMs, mainly due to the absence of oncology or radiology was a theme in many of the SAIs. Not all the SAI reviews commented on the inquorate nature of MDMs but comments were made in ten primary urological cancer cases of which two were quorate leaving eight non-quorate. The Team did not specify their definition of this but an analysis illustrates the reason is usually oncology non-attendance. Overall MDM quorum rates were as follows:

2017	11%
2018	22%
2019	0%
2020	5%

198. When an oncologist is not present the opportunity to discuss the place of radiotherapy and/or chemotherapy for suitable patients may be lost. Urologists can use their knowledge and initiative to suggest oncological referral as a treatment option but frequently they will be considering the surgical options for the patient which is their area of expertise. There is no reason why urologists cannot make a referral to oncology when the oncologists themselves have not been at the MDM.

199. The Inquiry accepted these findings and looked to see why these problems occurred with the operation of the Trust's urology MDM.

200. The problem of non-quoracy had been recognised previously after the Peer Review that took place in 2015.

201. In October 2016 the external verification report of the Peer Review of June 2015 of the urology MDM highlighted four serious concerns,[180] three of which were still an issue in 2017 and indeed when the nine SAIs were looked at in 2020. These were: the fact that there was no cover in place for the clinical oncologist and the consultant radiologist; quoracy was low due to this; and there was a long wait for routine referrals. Unfortunately, none of these serious concerns were addressed, leading Dr Hughes in his overarching report to say:

> "The systems of governance within the Urology SHSCT Cancer Services were ineffective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent whole patient journey and did not focus on areas of known concern. Assurances given to Peer review were not based on systematic audit of care given by all."[181]

202. The reasons for long waiting lists are referenced above. Essentially, demand for services outstrips the Trust's, and indeed the region's, capacity to meet it. The

180 TRU-98213 to TRU-98219
181 WIT-84304

Inquiry examined the reasons for lack of quoracy in the urology MDM and what was done following the Peer Review.

203. Peer review was not overseen or challenged regularly at Trust level or indeed at regional level. It appears that the original process was accompanied by an assessment and then a follow up. However, there was no subsequent external challenge. The Inquiry considers that it would have been appropriate for the Trust to have an internal process involving the commissioners. More is said about this in the Governance chapter.

204. It is recorded that from early 2015 one of the greatest challenges for the MDT has been the irregular attendance of a clinical oncologist and a radiologist at MDMs. It appears that there has been a chronic inability to recruit adequate numbers of clinical oncologists and radiologists. Even where an oncologist is recorded as having attended the MDM, they may not actually have been present for the duration of the meeting as required.[182] Efforts have been made to recruit. Mr Barry Conway indicated that since the commencement of his role in Cancer and Clinical Services (from 01 June 2018), 11 attempts have been made to recruit radiologists, including three attempts to recruit radiologists with expertise in urology. In January 2021 the Trust was successful in appointing a Consultant Radiologist with expertise in urology.[183]

205. The issues regarding recruitment were added to the risk registers and efforts were made to try to improve the quoracy in conjunction with the Cancer Centre in Belfast.

206. With regard to peer review, the point was made by Ms Fiona Reddick, that:

> "clinicians, not just in urology, felt sometimes that peer review was a tick box exercise because there were things out with our control that required commissioning that just wasn't forthcoming. So, there wasn't really any control

182 AOB-77584
183 WIT-23876

from peer review to say no, don't do this any longer or, you know, stop it, it's not viable. There was no direction."[184]

This demonstrates that peer review was not being used effectively as the tool for improvement that it was designed to be. Part of the reason for this inefficacy results from the lack of leadership from Cancer Services. More is said about this in the Governance and Medical Management and Leadership chapters.

207. Cancer Services received medical input from an Associate Medical Director for cancer and support services and a CD for cancer. The job descriptions[185] emphasise roles predominantly concerned with the management of medical staff, although they do refer to working with the various operational directors to ensure high quality care. The CD role relates to oncology, palliative care and the chemotherapy unit only. The full scope of the Divisional Director in terms of links to the other directorates that treat cancer patients is not clarified. The job descriptions were revised in 2024, [186] and while there is now greater emphasis on quality there does not seem to be any articulation of a clear overarching medical role that contributes to a Trust-wide strategic direction that covers all the aspects of cancer care across all directorates. The reports from Cancer Services into the Board Performance Committee[187] focus on resolving issues relating to access targets. They do not refer to any performance against any overarching cancer plan that considers both access targets and quality of service. This is despite the fact that the need to set up a cancer strategy forum was referenced in a report to the performance committee in March 2020 as an action planned. Overall, the medical leadership roles still do not seem to have sufficient emphasis on strategic development. This is discussed in more detail in the Medical Management and Leadership chapter.

208. Ms Reddick did recognise that there was a shortage of personnel:

184 TRA-05735, lines 2-8
185 TRU-02587 to TRU-02602; TRU-162786 to TRU-162791
186 TRU-305887 to TRU-305893; TRU-305894 to TRU-305900
187 TRU-159341 to TRU-159342

> "The cancer team flagged and escalated delays regularly with the Urology Head of Service. MDM attendance (Urology) - there have been challenges with attendance at Urology MDM meetings in particular from Radiology and Oncology. This was escalated to HSCB and there were regular regional Oncology Pressures meetings to try to address this. There was also some regional work done to explore other ways of working within MDTs - set up pathways. Urology MDTs were explored but this work was not taken forward by HSCB as clinicians were concerned that there would be too many protocols required for Urology patients as pathways were multi-faceted. There is an ongoing challenge with recruitment of Oncologists across the region and this has been well recognised at Department of Health level, and this continues."[188]

209. She told the Inquiry:

> "From a point of view of the oncologist gaps and the radiologist, unfortunately at that time we did have deficits in Oncology. The Oncology Services obviously, it's like a hub and spoke model, the Cancer Centre was in Belfast and the oncologist came out from the Cancer Centre to the units. At that time, 2015, there was a regional roll-out of acute oncology consultants. We also were preparing to open the Northwest Cancer Centre, and there just wasn't enough oncologists to meet all of those needs. That was highlighted various times to Health and Social Care Board. Indeed, there was oncology pressures [sic] meetings regularly to see how we could cover the demand for services, and there just wasn't enough cover to meet all of the demands from a clinic provision, acute oncology, to MDT cover. There were gaps. Those were well recognised at department level.
>
> We did have then a piece of work started in 2018 led by the Health and Social Care Board, looking at oncology transformation and how we could try to bridge some of the gaps. That was a huge piece of work and there were lots of deficits. There was also a paper shared by the Health and Social Care Board where Cancer Research UK done [sic] a scoping exercise looking at how we could

188 WIT-91016 to WIT-91017, paragraph 25.2

actually make our MDTs more effective. There were a few workshops here where there was [sic] suggestions looking at protocolised discussions, and we were talking about piloting some of that. However, that never really was taken forward; it didn't really go anywhere.

We were trying and we were escalating and we were trying to actually see how we could improve the quoracy within MDT. So, there were lots of regional discussions to try and address some of the gaps."[189]

210. The Inquiry heard from Dr Marc Williams, who was the consultant radiologist with a specialist interest in urology and the lead radiologist on the urology MDT. For the time period relevant to the Inquiry, he was the single-handed radiologist with a urology specialism and that created problems of quoracy for the urology MDM. If Dr Williams did not attend no other radiologist did so. He told the Inquiry why he may have been absent. He explained that he needed a Wednesday afternoon to prepare for a urology MDM on Thursday but that occasionally he had to carry out acute clinical work, which meant he would have no role in the MDM. He told us that the Trust:

"didn't really appreciate the need to keep both my Wednesday afternoon and the Thursday afternoon sessions free so as not to take my prep time. They maybe didn't appreciate that. In addition, I was the sole person available. I will just summarise the other things so I can tell you there. So, if I took leave on a Wednesday afternoon or a Thursday afternoon or study leave on either of those days. So, all of those things were the reason why I wouldn't be at an MDT."[190]

211. In his witness statement he felt that the Trust:

189 TRA-05705, line 11 to TRA-05706, line 16
190 TRA-05751, line 23 to TRA-05752, line 3

"did not do all it could to appoint an additional radiologist by making an attractive job, particularly when in competition with other Trusts both within Northern Ireland and the UK."[191]

212. In evidence he expanded:

"The problem is that radiology is -- there's a shortage, a big shortage of radiologists and a lot of places don't even advertise any more because they just can't fill their posts. So, newly qualified radiologists can almost pick and choose where they want to work. The departments have to make themselves as attractive as possible to those people who are coming, which, it's difficult, you know, in Northern Ireland, because they're relying, you know, mostly to the extent on northern Irish trainees coming through the programme who generally don't have much of an interest in uroradiology as opposed to the UK -- to England, sorry, where there are a lot of uroradiologists. But here there seem to be quite few, you know, if any really. So they're perhaps not exposed to that specialty and, therefore, not really enthused to do it. I think, you know, there is a sort of combination of factors.

So, to be in competition with other Trusts within Northern Ireland and the rest of the UK, you have to do something extra to make your job appealing, whether it be an attractive job plan, the on-call is good. Because the on-call is always a problem and it's something, you know, applicants will look at, whether there's ability to work at home; any financial remuneration, things like that. You know, a good job advert, for example."[192]

213. Dr Williams admitted that another factor in his absence from the MDMs was the fact that he frequently took leave on a Thursday when the MDMs were held as he had no formal job plan commitments on a Friday. It was not possible to have the MDM on another day. The Inquiry recognises that Dr Williams was entitled to take his holiday leave but given that there was only Dr Williams who could do the job that was required at the urology MDM, the Inquiry questions the wisdom of a

191 WIT-60287, paragraph 20.3
192 TRA-05755, lines 1-28

job plan that essentially permitted repeated long weekends leaving the urology MDM inquorate, particularly in light of its own policy that:

> "the core members needed for a quorum or their cover should aim to attend all meetings so the MDT will be quorate for at least 95% of meetings."[193]

We consider that either the Trust ought to have been more flexible about the time of the meeting or ensured that Dr William's job plan specified that he attend a set number of MDMs.

214. We were told that the Trust tried to address the lack of radiologists by outsourcing to the independent sector. Dr Williams said that this was counterproductive in that, while it may have cleared the backlog it resulted in poor quality radiological reporting that neither he nor the clinicians trusted.[194]

215. Additionally, on at least two occasions where general radiologists stood in at MDM the right answer as to the radiological findings was not reached.[195]

216. Dr Williams' view was that he had raised issues and concerns and that:

> "it wasn't my problem to sort, it was someone else's problem."[196]

217. Clearly there is only so much that can be done in the absence of adequate resourcing and recruitment. Even when the Commissioner does provide the resource, the Trust has had and continues to have, difficulties with recruitment and retention. It is likely that this Inquiry and the attention directed at the urology service will not have assisted. The Inquiry, however, considers that this problem is not unique to the Trust and is an issue which requires urgent attention from the Department.

193 TRU-105287, paragraph 1.4
194 TRA-05768 to TRA-05770
195 TRA-05775 to TRA-05777
196 TRA-05774, lines 20-21

218. The Inquiry considers that more needs to be done to provide an attractive package for candidates both to incentivise candidates to come to Northern Ireland to work and, importantly, to remain here. We recognise that there are restraints on the financial packages that can be offered, although we believe consideration needs to be given to these. In our view more could be done to address the issue generally in Northern Ireland, but also specifically in the smaller hospital sites. Consideration could be given to a fully supported regional approach to re-designing services for the future. This could include some use of hub and spoke models, a range of development opportunities in education, research and medical management including roles as service transformation leads. Aside from financial packages, there should be some consideration of flexible working schedules.

219. The Inquiry heard evidence of how the MDM operated from the clinicians in the Trust's urology service.

220. An MDM makes recommendations rather than decisions. These recommendations can only be as good as the information available to the MDT at the meeting. The final decision on the way forward needs to be made by the patient in discussion with their clinician. MDTs should be told if there are significant changes to their recommendations and the reason for this so they can review and learn from these cases.

221. It is the responsibility of the clinician to ensure the treatment plan agreed at the MDM is followed. If a change in the plan is required, the clinician responsible for the patient's care should re-present the case at the next scheduled MDM and provide the reason for the change. In several of the cases which were considered by Dr Hughes and his review team, and in the themes that emerged from the SCRR outcome reports produced to the Inquiry, there is evidence of deviation from the treatment plan agreed at the MDM, but no indication that these cases were revisited by the MDT to discuss the change in plan.

222. The Inquiry was told that the other clinicians did not always refer cases back to the MDM when patients wished to go with a treatment plan different to that recommended by the MDM. Mr Glackin told the Inquiry that:

> "if you're going to vary from a recommendation, you'd need very good grounds to do it, and you need to record that, you need the consent of the patient. And I think as we've said, you would bring it back to the meeting if there's a significant variation."[197]

223. While he would not always refer a case back to MDM, for example if it transpired that a patient was unfit for a particular treatment:

> "then I would record that in the notes. It would be very clear to anybody coming behind me that this is the reason I've made this decision."[198]

224. The Inquiry has seen no evidence of any clear record in the RCA of the nine SAIs that would explain what discussions had taken place with the patients and why an MDM recommendation was not being followed. Overall, the nine SAIs revealed a need for increased clinical management and leadership of Cancer Services and for a formal input into the Board committees. This is discussed further in the Governance and Medical Management and Leadership chapters.

Implementation of Multidisciplinary Meeting decisions

225. The implementation of the MDM decision is normally done without question by clinical members of the team. Information available to the Inquiry has indicated that there were significant shortcomings in implementation of MDM decisions in several cases which put patients at risk. Seven of the nine SAIs in Dr Hughes' overarching report showed a failure to implement the MDM decision.[199] Further, it appears from the Trust's final SCRR analysis[200] that a significant number of

197 TRA-08300, lines 24-28
198 TRA-08301, lines 5-7
199 WIT-84300 to WIT-84301
200 TRU-408572 to TRU-408613

patients in the lookback review required changes in clinical management, a medication change and/or further referral. Some of these will likely have been as a result of the non-implementation of the MDM decision.

226. Following MDM discussion, the team will agree one or more options of treatment to be discussed with the patient and their family which will usually happen within one or two weeks. Surgical or oncology referrals to colleagues may be made and treatment instituted. It is assumed the clinician involved will offer all the treatment options and discuss relative merits and risks, but this is not generally audited.

227. The MDM process only works if the panel decision is relayed to the patient. One of the drawbacks of the MDM is that the clinical care of the patient is being discussed without the patient in attendance as this is usually the only way of getting through the caseload. What is important is that all the options are presented to the patient in an impartial way whenever the meeting with the patient post the MDM takes place, that the decision reached is recorded and, if necessary, the case is referred back to the MDM. In the Trust there was no culture for returning cases to the MDM for review. Mr O'Brien told us there simply wasn't time to refer back.

228. For significant MDT decision making it is important to stay impartial and this is where CNSs can act as a neutral and helpful influence. Where treatments have similar effectiveness such as radical radiotherapy vs radical surgery for localised prostate cancer, the CNS can assist in arranging for the patient to meet with both a urologist and a clinical oncologist so a balanced judgement can be made as to which option is the best for that individual patient. The Inquiry found there was no double-checking mechanism to establish whether decisions made at the MDM were correctly implemented, or departure from those decisions recorded.

229. Since the Inquiry Mr Haynes told us that monthly audits of MDM outcomes have been introduced and advocated for a formalised structure to allow patients to be brought back to MDM for discussion in order to enhance governance and patient

care.[201] The Inquiry agrees that the lack of such a formalised structure led to gaps in follow-up and governance. This requires to be addressed.

230. A further difficulty with the Trust's MDM operation evidenced by the cases was the lack of referral for specialist treatment. Some cases need to be presented to a Specialist MDM when the relevant specialist is not present at the MDM. In urology a subsection of urological cancers should be discussed and referred for sub-specialist or supra-regional centres in view of their rarity, or to support the development of specialist surgical and oncological techniques. These cases include: prostate cancers potentially suitable for radical prostatectomy; bladder cancers potentially suitable for radical cystectomy; small renal masses potentially suitable for partial nephrectomy or ablation; all testis cancers, which need to be seen by medical oncology; and all penile cancers.

231. Urologists are very familiar with standard pathways for all the common cancers. Mr O'Brien was co-author of the local NICaN guidelines and would have been especially cognisant of what was required.

232. For several of the SAI cases no referral or discussion was documented with the specialist team in Belfast. From the information available to the Inquiry there were shortcomings in the Specialist Multidisciplinary Meeting (SMDM) process of four cases which placed patients at risk and contributed to the SAIs.[202] In some instances, direct referrals recommended during MDMs were not actioned or documented properly. For example, a patient was reviewed in outpatients, but no correspondence or referral to oncology was made, despite MDM recommendations.[203] Similarly, some referrals were delayed or not made due to oversight or lack of follow-up. The tracking systems in place only monitored up to the first definitive treatment (e.g., hormone therapy) and did not extend to subsequent referrals, such as to oncology centers. This gap meant that onward referrals were not always visible or monitored within Cancer Services.

201 TRA-08725, lines 16-23
202 These were Patient 2, Patient 3, Patient 7 and Patient 10
203 TRA-00870 to TRA-00873 discussion regarding Patient 102

233. Clearly the Trust's governance systems were inadequate in highlighting this.

Cancer Nurse Specialist liaison and referral

234. For two decades specialist cancer nurses (CNSs) have worked alongside urologists and their oncological colleagues for the benefit of patients with cancer. In the Trust the urology CNSs dealt with both benign and cancer conditions.

235. In cancer care a CNS is a conventionally trained nurse who will usually have spent time in both general and specialist urological nursing then going on to sub-specialise in urological cancer care. There are three stages when the presence of a CNS is helpful. Firstly, at the initial consultation, secondly during the MDM/SMDM and thirdly when the patient comes back after the MDM for results and treatment planning. Nurses contribute to continuity and since the patient will have a contact telephone number, can chase up scans, blood results and planning decisions.

236. CNSs (sometimes referred to as key workers) are an essential part of the management of all patients with cancer especially at diagnosis. It is a worrying time for patients to have a new cancer diagnosis and the CNS has an important role in supporting, giving information and coordinating further care in the patient's treatment. This role is recognised in the NICE and NICaN Guidance which is followed by the Trust and the Urology Department. CNSs work closely with the urologists to see patients through their treatment journey. They can help to reassure patients where possible; provide good information either on paper or in electronic form; and be a contact for ongoing support.

237. At the initial consultation patients are understandably anxious when the diagnostic pathway is suggested and need support during diagnostic procedures. CNSs are often experienced in theatres and wards so can give insight into these procedures which the urologist may not have time to do in a busy clinic. The CNS can assist by spending some time afterwards explaining what is to happen.

238. If the CNS has met the patient and is aware of the patient's age, fitness and particular concerns, the CNS can helpfully contribute to the MDM discussion for the benefit of the patient. Such input is generally appreciated by the surgical team.

239. At the post-MDM consultation, the CNS will usually sit in with the consultant while the diagnostics and staging results are presented to the patient and treatment options are discussed. There can be much information for a patient and their family to take in, and patients often feel overwhelmed. The CNS will usually take the patient off for a further chat after the meeting with the consultant and again give the patient further information and support.

240. In some healthcare trusts many experienced CNSs will run independent clinics that assist in diagnosis or follow-up investigations. This enables consultants to concentrate on those cases that require differential diagnosis or further management decisions. Cancer nurse clinics also give the nurses an opportunity to double check that the MDM outcomes have been fully discussed and implemented with the patients and where necessary they can liaise with the clinician about the plan.

241. Lastly, in the palliative scenario CNSs will liaise with their colleagues in the community, providing a safe and seamless transfer of care.

242. Ms Leanne McCourt, CNS in the Trust, in her witness statement to the Inquiry quoted from Macmillan and NICaN to effectively sum up how a CNS benefits patients:

> "the role of the CNS as a keyworker is a supportive one. A patient's cancer journey can be complex and involve care from different teams at different points (e.g., Urologist and Clinical/Medical Oncologist). The CNS provides a constant link throughout this course and can achieve this by being a point of contact for queries or giving appropriate and relevant information. They can also liaise with other professionals involved in the patient's care. The CNS as

a keyworker can also signpost/ refer patients to other services that can offer tailored support for their needs, e.g., counselling or benefits advice."[204]

243. Information available to the Inquiry has indicated that there were significant shortcomings in the utilisation of CNSs in the Trust's urology service. The Trust stated in their Peer Review in 2017:

"all newly diagnosed patients have a Key Worker [cancer nurse] appointed, … adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner."[205]

244. Of the nine SAI cases considered involving Mr O'Brien's patients, none were seen initially by a CNS.[206] This was an important and unexpected finding in the investigation of the nine SAIs. There were several factors which allowed this situation to prevail including the method of key worker allocation, the availability of specialist nursing staff and the timing of Mr O'Brien's clinics.

245. There was evidence, including from the Trust's CNSs that there were not enough of them. Ms McCourt, in her witness statement, provided a Macmillan Partnership Application, which stated that:

"There is an overwhelming deficit in the number of CNSs within SHSCT." [207]

Ms Kate O'Neill told the Inquiry she did not consider that the roles and functions of CNS were properly resourced and that:

"The prolonged process to appoint additional CNS members contributed further to delays in service development."[208]

204 WIT-85949, paragraph 34.2
205 TRU-172142, points 6 and 7
206 WIT-84301
207 WIT-86491
208 WIT-80935, paragraph 23.1

246. In her witness statement she told us:

> "Given there was only one CNS with an Oncology focus, and the fact that this CNS still had managerial responsibility for the unit, it limited the ability to provide a CNS for each patient with a cancer diagnosis. While there were fluctuations as to how many Consultants were in place, during 2015 there were six, all holding one results clinic per week. At all times, Macmillan packs and information booklets containing contact cards were available within each consultation room. Where a CNS was not available this information could be provided by the Consultant."[209]

By the time of the SAI investigation there were two CNSs: Ms O'Neill and Ms McCourt. The Inquiry notes there are now five.

247. There was clear evidence that Mr O'Brien, through his involvement with Craigavon Urological Research and Education (CURE), had contributed towards the education and training of some of the Trust's CNSs and the Inquiry accepts that he valued their work. The fact remains, however, that those nine patients did not have key workers and none were present when they met with Mr O'Brien.

248. Mr Glackin's evidence to the Inquiry is that he spoke informally with two CNSs, Ms O'Neill and Ms McCourt. He said:

> "So I spoke informally to both Kate and Leanne and asked them what their experience was. Mr. O'Brien would not have had the CNS in the room at his clinics on every occasion, he may have invited them in for selected patients, and that was what I understood from those conversations.
> I also -- Leanne also relayed to me the encounter that she had with Mr. O'Brien regarding the key worker discussion, and she outlined that discussion which took place -- from my recollection she described it taking place in the small

209 WIT-80939, paragraph 26.1

kitchen in the Thorndale Unit. So that stuck in my mind as to a kind of important interaction that they had had on the key worker role. …

So Leanne McCourt described to me that she had advised Mr. O'Brien that she was available to be the key worker for his clinic, and he in turn spoke to her, and I'm relaying what she told me, that he didn't understand what the key worker was. "What is the key worker?", is the kind of substance of it. She was -- she described feeling a little bit taken aback and shocked by his language, and she relayed that story to me, and I think she's relayed it to you here as well.

So that to me kind of laid out that perhaps he wasn't as open to involving the CNSs as I was, that there was a difference in his approach."[210]

249. It was clear to the Inquiry that Mr O'Brien, who had lengthy discussions with patients, did not usually have a nurse in the room with him, did not identify a nurse to speak to the patient after he had seen them and did not always give them contact details for a nurse.

250. It appears that this situation was one which was in some way considered part of the way Mr O'Brien worked and was thought to be a consequence of his desire to give his patient his personal attention and the benefit of his years of experience. There does not appear to have been any major formal challenge to this from colleagues or from nurses.

251. The lack of a CNS made a significant difference to the patient's care pathway. The Inquiry considers it is likely that omissions in oncology referral and deficiencies in hormone treatment would have been recognised and acted upon had each patient had a CNS assigned to him. A good failsafe mechanism was therefore not available to these patients.

252. The absence of a CNS had a detrimental effect in the cases of Patient 1 and Patient 35. The Inquiry heard that lack of communication in both cases meant

210 TRA-08742, line 29 to TRA-08743, line 27

that no referral to community palliative cancer nurses took place until it was far too late. Also, Patient 35, whose cancer spread, did not have the benefit of a cancer nurse in the consultation or afterwards for backup.

253. Mr O'Brien admitted that the nine patients identified in the SAIs had not been allocated key workers. Mr O'Brien in his addendum witness statement and in his closing submission to the Inquiry,[211] argues that it was not his responsibility to allocate a key worker but rather the responsibility of the core nurse member of the MDT, according to the Urology Cancer MDT Operational Policy 2017. He contested Dr Hughes' view that clinicians had a primary responsibility to ensure that patients had access to key workers and their contact details. The Inquiry agrees with Dr Hughes. We fully recognise that it was not always possible to have a CNS present when Mr O'Brien met with his patients, but the contact information was available to every consultant at clinic and ought to have been used. The benefits of CNS involvement in patient care are well established. Even if the Inquiry were to accept Mr O'Brien's contention that allocation was not his responsibility, Mr O'Brien in seeking the best for his patients ought to have ensured that a key worker had in fact been allocated. While Mr O'Brien stated that he never excluded any CNSs from the care of his patients at clinics and requested their involvement in the care of his patients on many occasions,[212] the nine SAIs show that he did not ensure that all his patients were allocated a keyworker.

254. The Inquiry questioned other clinicians regarding their use of cancer nurses and heard, for example, when the CNS was unavailable to attend at the follow-up appointment, contact details would be given to the patient and a list of patients given to the CNS for follow-up.

255. This is another important area that could and should have been examined through the evolving MDT process. There ought to have been an evaluation of how the MDT was working and this could have provided an opportunity to assess

211 WIT-107611, paragraphs 146-150; SUB-00223, paragraph 134
212 WIT-82634, paragraph 12

whether agreed standards for cancer treatment are in place. The allocation of a key worker is a key standard and would normally be audited.

256. Ms Reddick, Head of Cancer Services, held responsibility for monitoring CNS activity including key worker allocation and holistic needs assessments. Although she managed CNSs over multiple tumour sites this did not include the urology service which sat under surgical services. She told the Inquiry that the Trust was moving to have a Cancer Nurse Forum across all tumour sites. She said that if urology had been under her remit there was the potential that she could have identified the fact that key workers had not been allocated to the nine SAI patients. She stated that she had highlighted the need for a key worker urology nurse to be allocated as part of a key performance indicator to Ms Corrigan (then head of urology services). She considered that communication from urology to Cancer Services was not always forthcoming and that if there had been more "joined up communication" things including the lack of key workers could have been dealt with sooner.[213]

257. The Inquiry fails to understand why a disconnect between Cancer Services and the Urology Services should have been permitted to occur, as that could lead to a situation where patients were disadvantaged. Cancer Services should coordinate across all services and have a leadership team that drives strategic direction and continual improvement of operational and quality standards in relation to cancer. This is discussed in more detail in the Governance and Medical Management and Leadership chapters.

258. Mr Haynes advised the Inquiry[214] that improvements include monthly snapshot audits of MDT recommendations to ensure follow-through, and an audit of key worker allocation. CaPPS now records the name of the key worker assigned to each patient either during or shortly after their MDT meeting and a report is run monthly from CaPPS to ensure that all patients are allocated a key worker.

213 TRA-05697, lines 18-21
214 See paragraph 229 above

259. Mr Haynes emphasised that these changes have led to greater visibility of individual clinicians' practices, reducing the risk of isolated or unsafe clinical decision-making. He described this visibility and data tracking as the most important change in the Trust in recent years, contributing to a safer environment for both patients and clinicians. More is said about the improvements made by the Trust in the Governance chapter.

Consenting patients

260. The GMC requires doctors to ensure patients are fully informed about their treatment so that they can effectively consent to it. The guidance in the relevant version of GMP states that "you must" to denote a legal or ethical duty. In the section: Domain 1: Knowledge, skills and performance' paragraphs 16 and 17 are relevant. They state:

> "16. In providing clinical care you must: …
>
> b provide effective treatments based on the best available evidence …
>
> d consult colleagues where appropriate …"[215]

Paragraph 17 states that a doctor:

> "must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research."[216]

The current version of GMP states that:

> "All patients have the right to be involved in decisions about their treatment and care, and be supported to make informed decisions if they are able to."[217]

215 INQ-30876
216 INQ-30876
217 INQ-30920, GMC GMP, dated January 2024, paragraph 24

261. It is a key standard of cancer care that a summary of the treatment plan should be sent to the patient's GP and communicated to the patient. Best practice is for a patient to receive a letter setting out what was discussed and what treatment was agreed. This is discussed more fully in the MHPS and Governance chapters. It appears from the evidence that Mr O'Brien did not routinely write to GPs and send a copy to the patient with a summary treatment plan after the completion of both the MDM and the first post MDM patient consultation. Writing directly to patients or copying patients into letters is not currently mandated in Northern Ireland.

262. From the evidence we heard from patients and families and from consideration of the SAI reports, the Inquiry is satisfied that some patients were not informed that they were receiving treatment that was unlicensed (in the case of Bicalutamide) or that departed from the MDM recommendation, or that they ought to have a key worker. Patient 18, who had prostate cancer, told the Inquiry in oral evidence that Mr O'Brien said to him that:

> "there was a programme where seven patients like me would be selected and I was one of them. They would see us on a regular basis regarding the effects of this hormone treatment"[218]

but, as Mr Hanbury discovered when he asked the patient, no formal study protocol or information was given to Patient 18.[219] The Inquiry did not seek further information from Mr O'Brien in oral evidence regarding this. Patient 18 gave evidence on the first day of oral hearings on 21 June 2022 when Mr O'Brien was in attendance. He had multiple opportunities to address this and indeed other patient evidence, either by asking the Inquiry to direct questions to the witnesses, in any of his witness statements, the first of which was received by the Inquiry on 04 November 2022, or in submissions. He did take the opportunity to provide detailed comments about other patients, for example Patient 35, in his witness

218 TRA-00075, lines 2-6
219 TRA-00071 to TRA-00072

statements. The Inquiry was concerned that Patient 18 did not receive treatment according to the MDM recommendation and believed that he was on some kind of experimental treatment. Mr O'Brien has subsequently told the Inquiry that Patient 18 was not part of any programme.

263. There is also no evidence that patients were informed that they were receiving nonstandard treatment and were in effect participating in an observational study, namely the use of IV antibiotics referred to above. One would have expected that such important matters would have been formally communicated in writing by way of a dictated letter.

264. The Inquiry considers that had Mr O'Brien kept clinic records in accordance with the GMC guidance, had he dictated letters following each clinic then there would have been a proper record of what patients had agreed or consented to. Further, had the Trust properly monitored their records the lack of detail would have been apparent. More is said about this in the urology section of the Governance chapter.

Hormone therapy for prostate cancer including use of Bicalutamide

265. Several of the safety issues that led to the Inquiry were not fully exposed until the SAIs were investigated and the lookback exercise commenced. It is therefore useful to consider in governance terms, why they escaped notice and what should have been in place to safeguard patients.

266. There was a striking finding in relation to Bicalutamide. This drug is recognised as effective in the treatment of prostate cancer. In 2008 NICE published a wide-ranging guideline for treatment in prostate cancer that was updated in 2014 and again in 2019 and 2021. That guidance also includes the recommendation that:

"People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care."[220]

267. Prostate cancer is usually affected by hormones, especially testosterone. Lowering testosterone levels, or blocking its effects in the body, can often shrink or slow the growth of prostate cancer. This kind of treatment is called androgen deprivation therapy (ADT) and is typically done with regular injections of special drugs known as luteinising hormone releasing (LHRH) agonists. However, over time, prostate cancers may stop responding to this treatment and learn to grow even when testosterone is very low – this is known as 'castrate resistant' prostate cancer.

268. One issue with LHRH agonist injections is that they can temporarily cause a surge or 'flare' in testosterone before lowering it. This flare isn't desirable, so doctors often prescribe a medicine called Bicalutamide (at a dose of 50mg) for about a month to help block the effects of this temporary spike. Sometimes, Bicalutamide at this dose is also used later on in hormone treatment for certain situations. It is not used or considered adequate treatment as a solo medication at this dose; indeed, there is evidence that Bicalutamide monotherapy is less effective than placebo for localised prostate cancer.[221]

269. Higher doses of Bicalutamide (150mg) can occasionally be used, especially when the cancer has spread widely (metastatic) or when a patient is very worried about the side effects of other hormone treatments, like erectile dysfunction. However, high dose Bicalutamide comes with drawbacks, such as causing breast tissue growth in men and may reduce survival compared to standard hormone treatment.

220 INQ-30274

221 See: Multi-disciplinary Team (MDT) Guidance for Managing Prostate Cancer September 2013 at TRU-177128 to TRU-177205, specifically TRU-177161 for study by Iversen. P., et al, BJU Int 2010; Apr;105(8): 1074-81

270. All drugs have side effects and hormone therapy is no exception. Normally hormone therapy is well tolerated by patients, especially the elderly and infirm. Hot flushes, weight gain, loss of genital hair, bone demineralisation and lack of libido causing erectile difficulties are the most common side effects and tend to come on gradually over a few months.

271. The main benefit of hormone therapy is that it shrinks cancer in the prostate, lymph nodes, and any areas where it has spread. It can also shrink non-cancerous prostate tissue, which helps improve urinary symptoms common in these patients.

272. Additionally, hormone therapy is often used before radiotherapy (treatment with radiation) because it makes the radiotherapy work better and reduces its side effects. For this reason, doctors often give patients hormone therapy for four to six months before starting radiotherapy and then continue it for another six months to two or three years.

273. Bicalutamide 50mg is specifically approved to help control the temporary testosterone flare around the time of the first hormone injection. Dr Hughes, in the nine SAIs looked at, noted that four patients had been prescribed Bicalutamide 50mg as a monotherapy by Mr O'Brien, contrary to NICE and European treatment guidelines.

274. However, the way it was being prescribed, and the extent of usage were not easily visible. Bicalutamide is classified as an Amber list drug in Northern Ireland. This means that it is initially prescribed by a hospital consultant and then the prescribing is transferred to the GP for long-term prescribing. Both initial and ongoing prescriptions are generally fulfilled through community pharmacies. If any pharmacy audit of outpatient hormone prescriptions had been done, this would have been detected. If there had been a full audit of MDT recommendations, then it would have been highlighted at this point. If there had been more challenge of the individual cases that were noticed, then a full audit could have been launched in the department at that time.

275. In effect all of these things would form part of good governance and should have been done. There was, therefore, no full discussion and debate regarding Mr O'Brien's practice relating to Bicalutamide. He would have been aware that he was prescribing outside of NICaN guidelines as he chaired NICaN when the guidelines were produced. It is of note that they were never signed off during this time. Moreover, the Inquiry heard the evidence of Dr Darren Mitchell relating to his attempts to ensure that Mr O'Brien stopped prescribing Bicalutamide 50mg as a monotherapy.[222]

276. Although drugs are often used outside of licence, best practice would require this to be justified and explained. In the case of this drug used in this way for prostate cancer, the logical place to document discussions relating to Bicalutamide would be the MDT meeting.

277. There was in general a failure to bring patients back to the MDT for discussion when their management had changed after the original plan. Most of the consultants did say they would do this whenever possible, and it is recognised, accepted practice in cancer care. This did not happen for many of Mr O'Brien's patients, and it appears that this was also not formally noticed. An evolving MDT process should consider these kinds of issues on a regular basis and put in steps to address any weaknesses. Cancer Services should provide leadership in this area. Dr Hughes was critical of the Trust's Cancer Services, its lack of interest in, or acceptance of, responsibility for the nine SAIs. In his witness statement he said:

> "The Clinical and Managerial Leadership of Cancer services had no knowledge or insight into the problems identified within the SAI processes. There was lack of understanding of services how were delivered elsewhere [sic] and what constituted open and transparent governance in a complex multidisciplinary healthcare setting. Some of their concerns did not reflect views as expressed

222 See paragraphs 283, 287, 289 and 293 below

by the Urology Cancer MDT members and there was a disconnect between senior level clinical management and MDT teams. This was clearly evidenced by Statements made to External Peer Review of Urology Services."[223]

This is discussed further in the Medical Management and Leadership chapter.

278. Following on from the SAIs conducted by Dr Hughes, Dr Tracey Boyce, the Trust's Director of Pharmacy was tasked to identify any other patients who were prescribed Bicalutamide 50mg.

279. She then carried out an audit of patients who received a prescription for Bicalutamide between March and August 2020.[224] This audit was not confined to the Trust. The purpose of the audit was:

- "To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage
- To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages
- To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care [sic]
- To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale."[225]

280. The audit found that:

"A total of 466 patients was identified from the Western, Northern and Southern Local Commissioning Group areas as having received a prescription for Bicalutamide 50mg.

223 WIT-84171
224 WIT-20088
225 WIT-20088

34 of these patients were identified as being on the incorrect treatment as determined by the clinical indications above. 2 patients had been commenced on the medication by services outside of NI Urology (1 by GP, 1 in South Africa in 2005 and continued following move to NI).

Of the remaining 32 patients 31 had been commenced on the low dose Bicalutamide by Mr O'Brien. 1 patient had been correctly commenced by Mr O'Brien on combined androgen blockade (LHRHa and 50mg bicalutamide) and had been switched to intermittent treatment by another Southern Trust Locum Consultant Urologist ... on review. However only the LHRHa (rather than both treatments) had been stopped at the time of this switch.

This patient has since been reviewed by the oncology team and the Bicalutamide discontinued.

From the remaining 31 patients, 2 [material redacted by USI] were subjects of 2020 SAIs (conducted by Dr Dermot Hughes) and had already been reviewed and management changed."[226]

281. The audit also looked at the patients receiving high dose Bicalutamide (150mg) to see if they had previously been prescribed a low dose:

"This was to determine if additional patients currently receiving the 150mg dose had previously been treated with low dose Bicalutamide as this practice had been identified in some patients and to ensure this use was in line with recognised indications. In addition for those patients receiving monotherapy alone records were assessed to see if Multi-disciplinary Meeting (MDM) recommendations / curative treatment options had been discussed / offered to the patient."[227]

282. Out of 298 identified from the Northern, Western and Southern trusts:

226 WIT-20089 to WIT-20090
227 WIT-20091

"• 26 patients, all of whom had their prostate cancer treatment initiated by Mr O'Brien were identified with concerns. No concerns were identified with the remaining 272.
• 1 patient [information redacted by USI] had already been identified and his care subject to an SAI.
• 1 patient was prescribed Bicalutamide monotherapy for metastatic disease with no evidence of discussion of reduced efficacy of treatment.
• 9 had initially been treated with low dose Bicalutamide which had then been increased to 150mg by Mr O'Brien.
• 21 patients there was no evidence of discussion of MDM recommendations of radical treatment or evidence of discussion of watchful waiting as an alternative to hormone manipulation."[228]

283. The Inquiry heard from Dr Mitchell, consultant oncologist with the Belfast Health and Social Services Trust, who received patients from the Southern Trust into the Regional Cancer Care Centre. In his evidence to the Inquiry, Dr Mitchell told us that he had raised long-standing concerns about the off-label use of Bicalutamide 50mg as monotherapy, which is not licensed for such use.[229]

284. He documented his concerns in a 2014 email to Mr O'Brien and later helped develop Regional Hormone Therapy Guidelines in 2015 to standardise practice.[230] He told us that he did this deliberately to address the issue and to try to stop Mr O'Brien's practice. Despite these efforts, there was no formal response or change in practice until a broader review in 2019.

285. Mr O'Brien believed that his practice relating to Bicalutamide was justified for each individual patient, and the Inquiry does not make any determination as to whether he is correct in that belief.[231]

228 WIT-20091
229 TRA-07771, line 9 to TRA-07804, line 20
230 WIT-96677
231 TRA-12551, line 12 to TRA-12577, line 18

286. When asked by the Inquiry about his use of Bicalutamide Mr O'Brien stated that he prescribed Bicalutamide (including 50mg doses), based on patient preferences and comorbidities, particularly cardiovascular risks. He acknowledged that this was sometimes outside guidelines but defended it as patient-centred care. He stated:

> "my approach to the whole thing has been, I have endeavoured -- and I think I believe I have succeeded in providing patients with all of the objective information that I have been able to access, for them to consider the risks and benefits of differing treatment options, including, in more recent years, brachytherapy and so forth, which I -- the quality of which provided by Belfast is outstandingly excellent, and set the MDM recommendations in that context, and give the patient time to consider it, and take it from there. And I -- you know, whether we should have a regimen that insists that irrespective -- that you don't even put it to the patient as to whether or not they want -- that they would like a referral to Oncology; that it is fundamental, you don't ask them, it just happens, is a counter view. It hasn't -- it's not that I disagree with it at all, but it's not the one that was practised with regard to our MDT. I don't know of anyone who practised that."[232]

287. Mr O'Brien admitted that he did not respond to Dr Mitchell's email and did not recall having read it.

288. Regardless of whether the prescription on Bicalutamide 50mg was appropriate treatment for an individual, Mr O'Brien admitted he did not bring back divergence from MDM recommendations to the MDT, nor did he record it.[233] The Inquiry has seen no evidence that patients or general practitioners were aware that Bicalutamide was being prescribed outside of its licensed use. We did hear from Patient 18 that he had been told he was part of a programme of seven patients selected by Mr O'Brien who would be seen on a regular basis regarding the

232 TRA-12576, line 29 to TRA-12577, line 18
233 TRA-12537 to TRA-12544

effects of the hormone treatment.[234] He wondered what Mr O'Brien meant by 'regularly' as he had had difficulty getting an appointment with Mr O'Brien, at which point, the Inquiry was told, Mr O'Brien provided the patient with a card. Patient 18 interpreted this as a card related to his private practice. Mr O'Brien did not address this in any of his witness statements and was not asked about it directly by the Inquiry when he gave evidence. He has subsequently provided the Inquiry with a copy of the card he says he was using at the time, which had contact details for the department at CAH on one side and contact details for Mr O'Brien's private service on the other. Mr O'Brien informed the Inquiry that he rejects giving Patient 18 his private card. Patient 18 did not respond to what he thought was an offer to be seen privately and instead, following discussion with his family, insisted on being referred for radiotherapy.

289. The Inquiry sought the views of the urology clinicians (see footnote)[235] who gave evidence regarding how they prescribed Bicalutamide 50mg, without exception all told us that they used Bicalutamide appropriately in accordance with its licensed use and never as a monotherapy.[236] Mr Tyson emphasised that prescribing off licence requires patient consent and documentation.[237] Dr Mitchell told us that he would correct the dosage for patients of Mr O'Brien who were transferred to his care in the Belfast Trust and tried to bring about a change in Mr O'Brien's practice.[238]

290. Mr Suresh advised the Inquiry that he identified one patient under Mr O'Brien's care on a regime of 50mg as a monotherapy and that he raised at MDM and documented his concerns but did not change the treatment immediately as the patient wished to speak to Mr O'Brien first. He told us that Mr O'Brien agreed to

234 TRA-00075 and paragraph 262 above

235 Mr Akhtar, Mr Haynes, Mr Glackin, Mr O'Donoghue, Mr Suresh, Mr Tyson, Mr Connolly, Mr Young and Professor O'Sullivan who corrected three cases that were referred to him where the patients had been prescribed Bicalutamide 50mg as a monotherapy: see WIT-96649, paragraph 1(iii) and TRA-08024 to TRA-08031

236 Mr Glackin acknowledged that he once reviewed a patient who had been prescribed 50mg Bicalutamide by Mr O'Brien and continued him on this dose, a decision which he now regrets and would not repeat. See TRA-08280 to TRA-08283

237 TRA-08932 to TRA-08933

238 TRA-07770 to TRA-07771; TRA-07777; TRA-07785 to TRA-07787

review the patient but did not dispute the consensus at the meeting.[239] This evidence confirms the Inquiry's view that being well aware that his prescribing practice was contrary to what his colleagues did and to best evidence, Mr O'Brien nonetheless continued to prescribe as he saw fit, regardless of the MDM view as to its appropriateness.

291. While Professor Roger Kirby[240] told us that Mr O'Brien's use of Bicalutamide was "a little bit idiosyncratic but I think justifiable",[241] his view however was that if there is a departure, for whatever reason, from the MDT recommendation that should be recorded, along with a plan of management:

> "I'd record that in the notes and then I'd be prepared to stand up in court and defend that on the basis of all the information."[242]

When questioned at length on the issue by Mr Wolfe this exchange took place:

> "Q. If the patient is to be prescribed a suboptimal dose -- you say Mr. O'Brien did nothing wrong but if he is being prescribed 50mg outside of the guidelines and outside of the licence, 50mg as a monotherapy, that has to be explained to the patient in terms of it being off licence and potentially suboptimal, and it has to be documented?
>
> A. Yes, I would agree with that. That should definitely have been the case, yes. A discussion should have taken place and it should have been documented."[243]

292. In discussion with the Chair, Professor Kirby:

> Q. "but I was struck by the fact that you kept referring to "ideally" things would happen. You used it in connection when you were explaining the

239 TRA -08631 to TRA-08633; WIT-50363 to WIT-50364, paragraph 49.3
240 See further at paragraphs 293, 392 and 395
241 TRA-09350, line 25
242 TRA-09371, lines 23-25
243 TRA-09418, lines 4-13

risk and benefit to document discussions with patients in the notes. You used the word "ideally" in that sense. But I`m sure that you would accept, would you not, that that is actually something basic rather than ideal?

A. Yes. I think the more that is written down now, the more important it is. You know, for example, the issue of consent. We just used to originally ask the patient to sign the form consent for a TURP, sign it, and go. Now you need a long explanation of what you've said to the patient and what they're committing themselves to. So, things are changing. The better the documentation, the better for the patient.

Q. The better for the patient and, arguably, for the surgeon also?

A. Yes.

Q. Because you have speculated about whether or not some of Mr. O'Brien's patients would not have wanted to travel to Belfast to get radiotherapy. We'll never know because it is not documented in some cases. Whether they would have wanted to retain their sexual function rather than have the particular androgen therapy; we again won't know because it is not documented. So while protecting the patient, it also protects the surgeon?

A. Yes, absolutely right. That's more and more important in an increasingly litigious society."[244]

293. The difficulty for Mr O'Brien is simply that while in individual cases he may have had good reason to use Bicalutamide in an unlicensed way, he may have discussed fully the pros and cons with his patients, but he did not document those thoughts and conversations. Moreover, the evidence before the Inquiry, particularly that of Dr Mitchell and Mr Suresh shows that Mr O'Brien knew that he was acting contrary to the way that his colleagues did, yet he ignored their views and did what he wanted. Some like Professor Kirby, may describe that as 'idiosyncratic', the Inquiry takes the view that it is evidence of acting contrary to modern practice of working as part of a team, in the best interests of patients, according to agreed guidelines.

244 TRA-09466, line 5 to TRA-09467, line 4

Non dictation of letters

294. The absence of letters following on from each clinic visit emerged as a significant problem. In many cases Mr O'Brien opted not to dictate letters on patients after each clinic and instead adopted the practice of writing a long summary letter after treatment concluded, usually many months later.

295. The GMC places emphasis on timely documentation of each patient contact. There is guidance relating to the standard of the notes taken and the key elements that must be covered.[245] The GMC does not explicitly state that a letter must be dictated after every patient contact.

296. It is, however, custom and practice for hospital doctors to dictate letters after each patient contact on most occasions. It is also custom and practice for this letter to contain key information regarding important tests, agreed treatments and key decisions made at the consultation. The letter also includes any necessary next steps, treatments and follow-up arrangements. It is regarded as a key communication tool for the patient, the GP and other clinicians. Most doctors would choose to dictate letters quickly after each visit while all the information is fresh in their minds, especially as much of that information may not actually be included in the written patient notes.

297. Repeated failure to dictate letters over many visits and over a prolonged time period (in the manner in which Mr O'Brien did) is totally outside normal practice and clearly risks patient safety and breaches the GMC standards with respect to continuity of care. The Inquiry saw that when Dr Ahmed Khan spoke to Mr O'Brien on this issue and quoted GMC guidance, Mr O'Brien was quick to challenge him as the GMC contemporaneous note mandate refers to written notes only.[246]

245 See paragraph 69 of GMP at INQ-30929
246 AOB-56442

298. The GMC does mandate that to ensure continuity of care patient information needs to be shared.[247] The normal way of sharing it is via a letter. The letter is normally dictated by the hospital doctor who has seen the patient and copied to any other doctors or nurses involved in the care of the patient. Increasingly the letter is written to the patient with a copy being sent to the GP, which is a practice the Inquiry considers ought to be mandated.

299. Moreover, what is written in patient notes can lack detail and the Inquiry saw evidence of this. The RCS report identified some issues relating to poor quality of the patients' notes as part of their commentary.[248] This is a common issue with patient notes and is usually compensated for by means of a good letter. Most hospitals would audit the standards of written medical records on a regular basis in order to improve their quality.

300. Lack of dictation after each clinic visit presented a gap in effective communication between colleagues, who need to be able to access relevant patient information to effectively review and treat patients, for managers who are arranging clinics and procedures, and most importantly for the patients themselves who need to be partners in their own care.

301. This came to light at several different points when colleagues were required to review some of Mr O'Brien's patients. Medical colleagues regarded this lack of dictated letters post clinic as unusual practice and noted that it necessitated additional patient reviews as they could often not determine Mr O'Brien's plans for his patients. For example, Mr Glackin in his statement to Dr Neta Chada in the MHPS investigation stated:

> "In terms of un-dictated clinics, I have participated in a look-back exercise and I know there are patient notes where the patient attended and there may be a brief entry on the chart but no letter in the chart. This has been a frequent finding of the look back exercise. There may be patients who have had a long

247 See paragraph 44 of GMP 2013-2024 at INQ-30883
248 TRU-345848 to TRU-345967

period of care with Mr O'Brien but it is not clear what discussions or actions have been taken, so anyone picking this up is essentially starting at the beginning because there was little detail in the note and no letter filed in the chart or on NIECR."[249]

Mr O'Donoghue when speaking to the Inquiry said that when he started in the department in 2014:

"The dictation, that was something I was aware of and I had noticed that within the first week of joining Craigavon because I did Mr. O'Brien's theatre list, because I had no patients of my own, and I noticed there were no letters in the notes. And it took a long time to work out why they were on the theatre list, so I was quite frustrated. So that's the first inkling I had that there was something going on with regard to dictation."[250]

Mr Haynes in oral evidence told us:

"Mr. O'Donoghue, seeing some patients who Mr. O'Brien had seen previously, and both of us raised a concern, along with Mr. Glackin and Mr. Young when they were doing it that you didn't have any documentation about the decision-making that had gone on before. There wasn't a letter available, and so it made reviewing these patients very difficult."[251]

302. The Trust information and governance systems failed to ensure that regular information in this area was provided to teams in order to drive improvement in standards regarding the timeliness of letters. No information was regularly collected to flag omitted letters after outpatient attendances or inpatient admissions.

249 TRU-258206, paragraph 30
250 TRA-08573, line 28 to TRA-08574, line 7
251 TRA-00867, line 26 to TRA-00868, line 3

303. Mr O'Brien defended his approach to dictation saying he preferred to wait for all results before dictating letters.

304. While attempts were made to address this, mainly via operational management and various reports were produced that covered the area of clinic letters, these largely related to delayed typing of letters for the purposes of secretarial workload. On 20 December 2016, for example, Mrs Katherine Robinson (Booking & Contact Centre Management) reported to Ms Anita Carroll (Assistant Director), that there were over 60 clinics going back to 24 November 2014 for which Mr O'Brien had not provided dictation, and she pointed to "a risk that something could be missed".[252] This information was then shared with the members of the Oversight Group. In the main the extent of the lack of dictation was not automatically measured or reported at any relevant meetings.

305. Mr O'Brien's secretary, Mrs Elliott, who would have had the most knowledge of the scale of the problem, did not effectively highlight or escalate the issue and it seemed that no significant, effective and directive pressure was applied in order to force better compliance with these basic but very important processes.

306. Mr O'Brien was not the only consultant behind with dictation although the extent of his backlog of letters was more significant than for others. His secretary received assurance from him that all the urgent letters were written. She accepted this. The issue therefore appeared to go back and forth between managers without resolution. It was not robustly raised or investigated until the time of the MHPS investigation and the events that led up to it.

307. In his grievance letter following the MHPS investigation, Mr O'Brien says that despite raising work pressures with Ms Corrigan, HOS, on more than one occasion, no:

252 TRU-255967 to TRU-255970

> "remedial or supportive plan or action was put in place to alleviate me of this overwhelming burden, which then gave rise to an administrative backlog in terms of dictation of letters, and which became a subject of concern."[253]

308. Although the recommendations in GMP do not specify a standard regarding the dictation of letters, the Inquiry considers that Mr O'Brien's practice did not meet with the intent of record keeping and communication. By leaving things as he did, Mr O'Brien's patients did not have a full and complete summary of each clinic visit as normally provided by a combination of the handwritten clinical note and the letter dictated to the GP and the patient. Instead, a significant number of patients had multiple visits with no letter dictated and a summary provided many months later. Other patients had letters dictated after lengthy delays.

309. Alongside the lack of dictation after each outpatient visit, many patients did not have a recorded clinical outcome provided by Mr O'Brien. Mr O'Brien's secretary, Mrs Elliott, told us in oral evidence:

> "The normal practice was Mr. O'Brien would have given me the outcome sheet when he had completed the dictation for that clinic. So whenever the outcome sheet was missing, I knew that there was dictation still outstanding."[254]

310. This resulted in difficulties for the operational teams who were responsible for planning clinics and procedures. These issues should have been formally highlighted through governance systems following the initial identification of the problem. This could have been achieved by making clinical letter completion a standard metric in a suite of data regarding clinic standards. If the problem continued to present itself, then intervention to remediate the practice should have been in place using the tools of normal medical management.

311. It appears that there were conversations designed to urge Mr O'Brien to change practice and that these were not effective. The first hint of any consequence for

253 AOB-02030
254 TRA-06179, lines 23-27

Mr O'Brien came when in March 2016 he was issued a letter instructing him to comply with standards in four areas.[255] Even at this time, the process was not handled in a way conducive to rapid improvement.[256]

312. It seems clear, and not only with the benefit of hindsight, that Mr O'Brien was a doctor in difficulty. As such, he needed to be managed through a structured improvement plan, properly constructed with appropriate advice and overseen in an agreed way. If the full extent of this problem had been clarified using standard data presented to the department, then it is unlikely it would have persisted unchecked for so long.

Notes at home

313. The GMC requires doctors to comply with information governance policies. GMC Leadership and Management for all doctors guidance came into effect on 12 March 2012 and was updated to take account of the regulation of physician associates and anaesthesia associates in December 2024. It states at paragraph 41 under the heading 'Information Governance':

> "Medical professionals need accurate, up-to-date and accessible information to deliver good and safe care to patients. Patients need to understand how information about them will be collected, stored and used and how their confidentiality and privacy will be protected. Good information governance systems can help to achieve this and contribute to providing high quality and safe care. They can also provide valuable information to allow teams and services to improve the quality and safety of care they deliver. All medical professionals have a role to play in contributing to these systems."[257]

It goes on to state that in respect of all doctors:

255 TRU-251418 to TRU-251419. This is discussed more fully in the MHPS and Medical Management and Leadership chapters
256 This is discussed more fully in the MHPS and Medical Management and Leadership chapters
257 INQ-30856, paragraph 41

> "You should be familiar with, and follow, the confidentiality, data protection and record management policies and procedures where you work and know where to get advice on these issues."[258]

314. Mr O'Brien kept large numbers of patient records at home. This was a breach of information governance guidelines and risked patient safety through lack of availability of patient records on the hospital site.

315. Records were kept in his home for inordinately lengthy periods of time. This contravened Information Governance standards for storage of medical records and was against Trust policies.

316. Additionally, due to the lack of a formal process for reporting information governance breaches within the Trust, this practice continued for several years.

317. The situation came about as the hospital failed to provide hospital transport for notes to peripheral clinics and thus relied on Mr O'Brien to transport notes in his own car. He then retained the notes at home awaiting dictation, which could be weeks or months later. This practice was known and condoned. Additionally, Mr O'Brien retained Trust notes on patients he was seeing privately at his home.

318. It was also apparent that Mr O'Brien regularly had large volumes of notes in his office in the hospital. There were often notes tracked out to his secretary which were in fact not held by the secretary and were not in Mr O'Brien's office but were at his home. This was only worked out by a process of elimination and involved a great deal of effort by administrative staff. Mr O'Brien did not seem to acknowledge the problems this messy situation caused for staff and for patients.

319. Mr O'Brien's approach to medical records was highly idiosyncratic. He used health service notes belonging to the Trust to make written notes regarding private patients seen in his own home.[259] This is wholly inappropriate. It would

258 INQ-30856, paragraph 44
259 TRA-04942; TRA-04946

have been appropriate if patients were seen as registered as private patients of the Trust, but this is not the case for these patients. Mr O'Brien told the Inquiry that patients he saw privately generally had diagnostic tests done in the health service. Afterwards he could have seen them privately, or more commonly they could have remained in the health service where he would see them at an outpatient clinic.[260] The Trust processes for documenting a change of status from private to public were not followed robustly as discussed further in the Governance chapter.

320. Mr O'Brien had a personal duty to keep his private and health service work separated in an agreed way and to avoid conflict of interest issues. He had a duty to ensure communications were sent in a timely way and to ensure that patient notes were stored according to best practice on hospital premises. He did eventually respond to demands to return notes but there is no evidence he reflected fully on his duties in this regard and to this extent he was failing to appreciate his responsibilities as set out in GMP.

321. The Trust did not operate a system of reporting information breaches regularly that would have revealed the volume of notes involved. Although Mr O'Brien was asked to return notes it appears no sanctions were threatened and no quantitative estimate of the issue was ever made until the time of the MHPS investigation when hundreds of patient records were returned from his home.

322. It seems that there was no real effort made to manage Mr O'Brien's conduct in this area using normal management tools and custom and practice and deference to a senior medical colleague prevailed.

323. Trust governance systems in the area of information governance and administrative standards for outpatients were insufficient. More is said about this in the MHPS and Governance chapters. However, we consider that Mr O'Brien should have complied with Trust information governance policies and his

260 TRA-04937

colleagues ought to have repeatedly highlighted the absence of files as a safety risk.

Administrative and secretarial service and communication

324. Administrative staff have a role in the oversight and monitoring of processes or have key roles in supporting clinical staff. These roles are a vital part of ensuring safe care. It is the administrative staff who ensure medical records are available for clinics, who support clinical letter dictation and the population of the patient administration systems (PAS). They monitor waiting lists and add patients to lists and collect information relating to, for example, waiting times, workloads and ministerial targets. Some of the administrative roles are particularly critical in terms of supporting clinicians, such as that of the medical secretary.

325. Other roles are so important that the individual is essentially part of the MDT as is the case with various cancer tracker roles. It is essential that administrative staff work closely with clinical teams and understand their critical role in providing safe services and feel empowered and trained to raise issues when required. The Inquiry was therefore interested in the perspective of administrative staff and heard evidence from a range of staff who worked in medical records and their managers, from cancer trackers and their managers and from Mr O'Brien's personal secretary, Mrs Elliott.

326. Good communication with patients, GPs, hospital medical and nursing colleagues and those in other institutions is essential for good medical care in both cancer and non-cancer scenarios. Hospital urologists have secretaries or personal assistants who normally would have a direct line and are responsible for the administrative support of their consultant.

327. In practice in a standard urology department a secretary will be responsible for letters, phone messages, administrative tasks such as communication with waiting list managers, MDM personnel, specialist and cancer nurses and the contact centre for booking appointments. They are also jointly responsible for

flagging up abnormal reports to the best of their ability, since they are not medically trained, and alerting the doctors to respond to these as appropriate.

328. Previously in the health service most consultants had an individual secretary, although current practice is that most are shared between two or even three colleagues. Throughout the time relevant to the Inquiry, Mr O'Brien had his own secretary in the Trust. He had a separate secretary who dealt with his private practice.

329. Mrs Elliott was Mr O'Brien's secretary from 2014 to 2020. She had a background in the health service dating back to 1987 and had experience in the Trust governance department prior to joining the Urology Department. She described her role as Mr O'Brien's secretary.[261] When she joined the department, she described the training and support for a role that included managing consultants' diaries, booking patients, clinical correspondence, monitoring various data inputs and receiving and answering numerous phone calls from patients, relatives and GPs, as inadequate.[262]

330. She described the impact of exceptionally long waiting times and capacity shortages resulting in frequent complaints and queries. This was especially the case in the winter months when only very urgent patients were admitted for surgery, causing widespread cancellations and further delays to scheduled procedures. Mrs Elliott felt that the delays and cancellations increased the administrative burden, required additional work over and above the normal working hours and in her eyes the pressure of this was underestimated by management. [263]

331. Although she reported to a line manager in the administrative team, on a day-to-day basis she had a close working relationship with Mr O'Brien and followed his direction and instructions in preference to any other.

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261 WIT-76326 to WIT-76329; WIT-76338 to WIT-76339
262 TRA-06123, line 1 to TRA-06125, line 4; WIT-76350 to WIT-76351; WIT-76337 to WIT-76338
263 WIT-76336 to WIT-76338, paragraphs 17 and 18

332. Mrs Elliott was aware of some critical issues in relation to patient safety and effective communication. For example, Mrs Elliott was aware that large numbers of notes were stored in Mr O'Brien's office, awaiting dictation after a clinic or for action after a result was requested. She acknowledged that there was a backlog in dictation although she could not determine the extent of same and that Mr O'Brien reassured her that any outstanding dictation was for routine cases. She also knew that he kept large numbers of notes at his home.

333. A consultant's secretary will have the lists of patients seen in a clinic and therefore will be able to check that all letters have been dictated. It is clear that Mr O'Brien's secretary did not check this had happened. She was certainly aware that there were many patients awaiting dictation and says that she did raise this with Mr O'Brien who assured her that all urgent letters were completed as required.[264] She awaited him returning outcome sheets once the entire day's clinic had been dictated. Accordingly, she had no definite idea of what was outstanding. At no point did Mrs Elliott challenge Mr O'Brien and try to rectify the situation.

334. She did not formally escalate this issue or reveal the practice of omitting dictation from some outpatient visits all together. The scale of the dictation delay was very significant; by late 2016 there were 61 clinics that had dictation delays.

335. Her view was that managers were aware of this and other administrative issues and it was not her role to challenge this situation.[265] She did acknowledge the difficulties in locating notes and the chaotic tracking procedures which were evident when notes were needed urgently.

336. It was only in the lead up to the MHPS investigation that senior administrative staff and their managers became aware of the extent of the problem. Ms Carroll, Assistant Directorate for Functional Support Services, commented:

264 WIT-76351 to WIT-76352
265 TRA-06221 to TRA-06222

"This incident demonstrated that this secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every clinic attendance on a timely basis. I would have expected that Noleen Elliott, Mr O'Brien's Secretary, would have been following up with her Consultant Mr O'Brien to advise that he had not dictated on clinics, also I would have expected that when she was aware of delays in dictation, she would have brought that to the attention of her SA Andrea Cunningham. If this had happened this would have been apparent on the backlog report and would be visible to myself, Katherine Robinson HOS RBC, Andrea Cunningham SA, Martina Corrigan HOS Urology and Ronan Carroll AD SEC and to the Urology Consultants."[266]

337. In a scenario where both surgical waiting lists and outpatient clinics have limited capacity and demand is great, a sizable portion of secretarial time will be spent on patient queries and liaison with consultants, contact centre and waiting list colleagues. Some patients write in with questions and queries, the secretary will match these up with the notes and put these in their consultant's in-tray for action. Often patients will telephone with queries. A secretary generally cannot readily answer a clinical query and should refer such queries to medical staff.

338. A large number of patient queries and concerns found their way to Mrs Elliott who describes passing them on to Mr O'Brien by way of email if they concerned patient symptoms, particularly deterioration in wellbeing.[267] She acknowledged that she often received no response from him and assumed he had contacted the patient directly.

339. The Inquiry heard from two patients who had experienced delayed replacement or removal of ureteric stents and described multiple calls to Mr O'Brien's secretary without effective response. The harm and delays in treatment were significant for

266 WIT-21302 to WIT-21303, paragraph 24.9
267 WIT-76349

these patients and illustrate the serious consequence of poor communication procedures.[268]

340. The impression formed by the Inquiry was that Mrs Elliott had an undue sense of loyalty to Mr O'Brien. She dealt with patients inappropriately by 'fobbing them off' and making them feel guilty that there were more seriously ill patients who required Mr O'Brien's time.[269]

341. Mrs Elliott's response to the suggestion that she 'fobbed off' patients was:

> "I wouldn't say fobbed off. I see there where it mentioned that I said that he couldn't speak with the clinician. I would never have said that, I would have said that a clinician was not available. Because clinicians generally didn't sit in secretaries' offices, they were on the busy ward. Unless it was something really urgent, they wouldn't have time to take telephone calls from all the people that would have rung in. So, the best thing for me to do there was to e-mail Mr. O'Brien, and that's what I did."[270]

342. She said that Mr O'Brien's patients were added to PAS waiting list reliably for stent replacement in accordance with instructions received by Mr O'Brien when he discharged the patient. He then identified an appropriate point to add the patient to his waiting list to remove the stent.

343. Mrs Elliott followed Mr O' Brien's instructions in terms of how she managed issues such as patients being added to waiting lists for procedures, patients being added to outpatient waiting lists and the procedures relating to the notes of patients who had investigations and investigation results pending.

344. DARO was a mechanism which helped to direct attention to the need to act on results and which helped ensure patients who needed further treatment moved

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268 See evidence of Patient 16 and Patient 84 in the Patient chapter
269 TRA-00088, line 10, Patient 84 described being 'fobbed off'
270 TRA-06156, lines 14-23

up the waiting list. Mrs Elliott was aware that Mr O'Brien did not use the DARO process in the way the other consultants and registrars did. In her view this issue was well known and it was not her role to escalate deviation from the agreed process.[271]

345. At times she was unable to comply with requests from her line manager to provide data on dictation backlogs or DARO.[272] In addition, there were deficiencies in the monitoring metrics particularly for dictation as highlighted by Mr Haynes.[273]

346. She described feeling harassed by management enquiries during the monitoring of Mr O'Brien after the MHPS investigation began and also being unsupported and isolated during this time:

> "A. Just the whole process, I find it difficult because I was sworn to secrecy and told not to talk about it, so I felt very isolated.
> Q. Yes. Just let me understand what that means. So sworn to secrecy, by who?
> A. Well, the emails I got about the MHPS process was highlighted in strict confidential and I wasn't allowed to talk to anybody about it.
> Q. Yes, and you respected that?
> A. I did. Well, I confided in one friend who was outside the Urology Service.
> Q. Yes. You felt isolated?
> A. I did.
> Q. And unsupported; is that fair?
> A. Yes, I did."[274]

347. Mrs Elliott felt overworked and undervalued by management but had great loyalty to Mr O'Brien. She did understand the impact on patients of long waiting times, repeated further delays and poor communication regarding appointments and procedures but felt unable to help the patients who were ringing her as there were

271 TRA-06229 to TRA-06239; WIT-76334 to WIT-76335, paragraphs 12.2 to 12.3
272 See evidence of Mrs Robinson at TRA-05207 to TRA-05210
273 TRA-00856 to TRA-00857; TRA-00876 to TRA-00877; TRA-00972 to TRA-00975
274 TRA-06102, line 21 to TRA-06103, line 6

so many unpredictable factors. Instead, she was in the habit of using a standard narrative provided by management when she spoke to patients unless they said their health had deteriorated in which case she emailed Mr O'Brien. It is disappointing and surprising that she did not make more effort to follow up the patient queries and contact them directly to update plans when she knew patients were often left "in the dark."[275] She assumed that Mr O'Brien had contacted these patients himself.

348. Mrs Elliott was aware of Mr O'Brien's practice in relation to private patients particularly with respect to taking charts home for these patients. She describes tracking notes to a private patient cabinet which was in fact usually not the correct location as many of the notes were at his home. She was able to direct private patient matters to Mr O'Brien's private secretary (who also worked at the Trust) or to Mrs O'Brien who was able to direct calls as required. Mrs Elliott did not appear to be involved in the paperwork required for private patients to be accepted into the health service with a change of status transfer form, rather she accepted private patients as health service patients when requested to do so.[276]

349. Mrs Elliott, like many administrative staff, could have raised more issues in relation to problems with the administrative practices of Mr O'Brien. She had the best information relating to the extent of the problem but was loathe to raise any issues at all. In general, her view was that 'management' were aware so there was no more she could do. In addition, her personal loyalty to a hard-working consultant seemed to override her concern for patients. This was particularly marked in relation to the administrative process of DARO.[277] The process was, that a patient who was awaiting results prior to a decision regarding follow-up treatment being made, were to be marked as discharged rather than given a review appointment on the outpatient list. Mrs Elliott was aware that Mr O'Brien did not use the system as intended, instead he continued to list his patients for review appointments. She was aware how he should have been using it but

275 TRA-06152, lines 16-17
276 TRA-06266 to TRA-06271
277 See paragraphs 150, 151, 344, 345, 350, 371, 445 in this chapter and paragraphs 406 and 407 of the Governance chapter

accepted his decision.[278] The issue was apparently not formally raised with medical managers at this time, although failure to look at radiology results was an ongoing problem for which an electronic solution has now been implemented.

350. In general, administrative staff reported issues to their immediate manager and managers of sufficient seniority would take issues up with a medical manager. The comment from Mrs Robinson regarding consultant staff "you see them as 100 times more important than we will ever be" reveals much about hierarchy and the operational/clinical divide reported by many staff.[279] In terms of administrative processes such as DARO it almost certainly would have been implemented more quickly if there had been full clinical engagement as part of the design with clinical and administrative staff working together as equal partners.

351. A consultant should not have been allowed to use the power of veto to refuse to comply with an agreed process and the medical managers should have grasped this issue earlier. Throughout the evidence there was a focus from staff on processes and structures that allowed responsibility to filter up silos of management with the final responsibility being unclear. As Dr Hughes said in his comment in oral evidence in relation to culture:

> "I think the culture was inappropriate. Too frequently. The culture was based around on a name as opposed to how does this affect a patient."[280]

352. Overall, in a culture where consultant medical staff and medical managers struggle to challenge a senior consultant who chooses to practice idiosyncratically it is not surprising that a personal secretary and other administrative and operational staff failed to grapple with the issues before the Inquiry.

278 WIT-76334, paragraph 12.2
279 TRA-05234, lines 28-29
280 TRA-01974, lines 2-5

353. The Inquiry considers that there should be clear guidelines for secretaries and other administrative staff who receive queries and there should be more assistance for patients to help them navigate the plans for their care (see Patients chapter). The Inquiry believes that there is a need for better training for medical secretaries and other administrative staff. Their key role in patient safety ought to be emphasised and they should be supported to speak out when persistent problems are clearly having an impact on patients. Mrs Elliott did not feel that she was trained in these matters or should be expected to challenge consultant staff. She apparently coped with the situation by just accepting it. She said:

> "I don't know how a secretary can encourage any clinician to do anything different than what he is doing."[281]

354. Clear training, to emphasise every person's role in protecting patient safety, along with organisational messaging, prioritising patient safety and quality of care, as part of a programme of cultural change emphasising the importance of the whole team, will be required.

Private patients

355. A further issue regarding Mr O'Brien's practice was how he handled his private patients. Unlike many surgeons Mr O'Brien did not carry out consultations, investigations or operations in private facilities, instead he saw patients privately at home in a designated office area and then those who required surgical or other interventions were treated in Trust facilities at which point he considered them to be Health Service (HSC) patients.

356. The Trust had recognised procedures to allow private patients to be transferred to the health service which required the consultant to complete a change of status form and for this form to be authorised by the Trust. Unless such a form was completed the patients were theoretically still private patients and liable for the cost of treatment incurred.

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281 TRA-06206, lines 3-5

357. Moreover, private patients transferred into the health service must access treatment and investigations within the same timescales as if they were HSC patients. This requires a process whereby the private patients are added to Trust waiting lists for any tests or procedures needed and at that point they could be classified according to urgency.

358. There are some circumstances where private patients are considered urgent at the point when they are first seen and an immediate transfer to the health service can be considered.

359. Mr O'Brien's private patients were seen at his private residence and had easy access to him via his wife if they felt they were deteriorating. It was noted that his private patients sometimes seemed to appear on operating lists when they had not been on Trust waiting lists. Mr O' Brien argued that he only did this when they had become urgent, however it was shown that he had not put them on the waiting list at the time when he first thought that they might need an operation.[282] While health service patients waited on a list without access to Mr O'Brien to describe their deteriorating symptoms, his private patients could ring up to make their case with comparative ease as they could ring Mrs O'Brien to say they would like to speak to Mr O'Brien. If they rang Mrs Elliott, she would refer them on. Many health service patients were not able to get advice and guidance in this way although they did have the option of contacting their general practitioner.

360. Whether or not Mr O'Brien's private patients required to be treated as urgent is irrelevant. The Inquiry considers that by advantaging them he was unfair to the Trust patients who were waiting their turn on the list. Equally, doing so could be regarded as a conflict of interest which was never declared, as his private patients had access to him in a way that his health service patients did not. This meant that the urgency assessment was not equitable, particularly as there was no ongoing assessment for HSC patients on waiting lists. Again, this is contrary to

282 See discussion between Mr O'Brien and Inquiry Counsel at TRA-04953 to TRA-04965

GMC Leadership and Management standards set out at paragraphs 85 and 86 directed to all medical professionals:

"85 If you make decisions about access to treatments on a case by case basis, without referring to agreed policy or guidelines, you risk introducing elements of unfair discrimination or may fail to consider properly the patient's other legal rights. When making decisions about using resources, you must do the following.

1. Provide the best service possible within the resources available, taking account of your responsibilities towards your patients and the wider population.
2. Be familiar with any local and national policies that set out agreed criteria for access to a particular treatment.
3. Make sure that decisions about setting priorities that affect patients are fair and based on clinical need and the likely effectiveness of treatments, and are not based on factors that may introduce discriminatory access to care.
4. Be open and honest with patients and the rest of the healthcare team about the decision-making process and the criteria for setting priorities in individual cases.

86. You should involve colleagues, including other healthcare professionals, in discussions about how to allocate wider resources. If issues or disputes about allocating resources arise, you should try to sort them out by discussing options with, for example, patients, the healthcare team, other colleagues (including other health and social care professionals) and managers. You should be open and honest with patients when resource constraints may affect the treatment options available."[283]

283 INQ-30862, paragraphs 85 and 86

361. This practice does not meet with normal standards of integrity demanded of a medical professional. In addition, it was not dealt with by medical colleagues in a satisfactory manner. The issue was raised by Mr Haynes and was added to the MHPS investigation. During that investigation the most that was done is that Mr Young was asked to look at several cases of Mr O'Brien's and give his opinion as to whether the patients had been advantaged. This was not a proper way to investigate the matter.

362. It is incumbent on doctors to keep up to date with policies relevant to their work. While Mr O'Brien's way of dealing with private patients was contrary to Trust policy regarding private patients, the Trust failed to audit its own policies in this area and apparently tolerated poor practice without sanction; this was a failure of governance.

363. A further issue which the Inquiry noted in relation to Mr O'Brien's private practice was the incident involving Patient 18. Patient 18 told us that when he complained to Mr O'Brien regarding his difficulty in getting an appointment with him, Mr O'Brien produced what the patient believed was his private card.[284] Mr O'Brien was not directly asked by the Inquiry for his version of the encounter with Patient 18, although as previously stated, he could have given it in a variety of ways. The Inquiry considers that if this had been intended as an invitation to consult Mr O'Brien privately then this would have been entirely unethical on Mr O'Brien's part. It is one thing if a patient asks whether it is possible to see a clinician privately and quite another for a clinician unsolicited to offer to see a health service patient privately. Moreover, in the Inquiry's view, it is contrary to GMP regarding managing conflicts of interest, which states a doctor:

> "must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients."[285]

284 See Patients chapter, paragraph 27 and paragraph 288 above.
285 INQ-30997

The urology team

364. A lack of effective teamwork is often identified as a contributory factor when things go wrong in healthcare and was a feature in many inquiries including the Francis Report,[286] the East Kent Report[287] and the Ockenden Report.[288] Yet in the NHS, staff surveys continue to show that teamwork is not as well embedded as it should be.

365. A number of publications deal with the issue of teamworking. The NHS England guide to improving patient safety[289] has some useful summaries of the conditions required for a team to work well and several studies show that teamworking is more difficult in certain circumstances but there is no argument regarding its importance.

366. Some simple interventions such as the World Health Organisation (WHO) checklist for safer surgery make attempts to ensure that all members of the team have an imperative to contribute to the shared aim of a successful operation for an individual patient. This works well and reduces harm.[290]

367. A clinical team needs to be able to think broadly about risk in their service, share a common set of aims, understand how to navigate the regulatory and organisational imperatives and work together in a way that is civil but also encourages open discussion and learning from error. This requires good leadership and for clinicians it requires constant attention to the duties defined by professional bodies.[291]

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286 Francis, R. (2013) “Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry”. At: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

287 Kirkup, B. (2022). “Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation”. At: INQ-31167 to INQ-31358

288 Ockenden, D. (2022). “Final report of the Ockenden review”. At: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

289 See: NHS England (2023). “Improving patient safety culture – a practical guide”. At: https://www.england.nhs.uk/publication/improving-patient-safety-culture-a-practical-guide/

290 See: Dtsch Arztebl Int. (2012). “The effect of the WHO Surgical Safety Checklist on complication rate and communication”. At: https://di.aerzteblatt.de/int/archive/article/131757

291 See: Salas, E. (2005). “Is there a “Big Five” in Teamwork?”. At: https://journals.sagepub.com/doi/abs/10.1177/1046496405277134

368. GMP 2012-2024 at paragraphs 35 to 37 deals with 'Working collaboratively with colleagues' and states:

> "35 You must work collaboratively with colleagues, respecting their skills and contributions.
> 36 You must treat colleagues fairly and with respect.
> 37 You must be aware of how your behaviour may influence others within and outside the team."[292]

369. GMC Leadership and Management in relation to working with colleagues states:

> "3. Most medical professionals work in multidisciplinary teams. The work of these teams is primarily focused on the needs and safety of patients. The formal leader of the team is accountable for the performance of the team, but the responsibility for identifying problems, solving them and taking the appropriate action is shared by the team as a whole.
> 4. You must be willing to work with other people and teams to maintain and improve performance and change systems where this is necessary for the benefit of patients.
> 5. You should respect the leadership and management roles of other team members, including non-medical colleagues."[293]

It goes on to say:

> "6. It is essential for good and safe patient care that medical professionals work effectively with colleagues from other health and social care disciplines, both within and between teams and organisations. Whatever the composition of the teams you work in, you must respect and value each person's skills and contribution."[294]

292 INQ-30882
293 INQ-30851
294 INQ-30851

370. The Inquiry sought evidence from the other clinicians who worked in the Trust's urology service to ascertain: how the team worked together; find out about how each dealt with their practices in light of the demand/capacity mismatch; whether they had any concerns about Mr O'Brien and his practice; and if so whether they sought to address those concerns and how.

371. Mr Haynes consistently raised concerns about Mr O'Brien's practice, particularly around administrative processes, triage, and engagement with governance systems. He stated that he never had similar concerns about any other colleague.[295] He cited an incident where Mr O'Brien refused to engage with the DARO safety net process, which tracks scan results. Mr Haynes escalated this to Dr Richard Wright.[296]

372. Mr Haynes described Mr O'Brien as having a non-standard way of working, such as not using dictation services, taking notes home, and failing to use administrative support that was available in the Trust. Alongside Mr O'Donoghue, Mr Young, and Mr Glackin, Mr Haynes raised concerns about the lack of documentation and decision-making trails in Mr O'Brien's patient records.[297] He expressed regret for not recognising earlier that Mr O'Brien's practice might have broader deficiencies and acknowledged that a comprehensive review should have been conducted sooner. It was Mr Haynes who raised the private patient issue. Mr Haynes in his evidence quoted in the Medical Management and Leadership chapter, revealed that the team dynamic was not open as he was fearful of challenging his colleague directly and openly.

373. Mr Young was the Urology Department's CL. He did not challenge Mr O'Brien formally, although he spoke to him about issues raised with him informally. He never escalated issues to the CD or MD believing that operational management may have done so.[298] On a number of occasions he took on additional triage to

295 TRA-00865
296 TRA-00865 to TRA-00866
297 TRA-00867 to TRA-00868
298 TRA-09596 to TRA-09598; TRA-09626; TRA-09802

ease the load for Mr O'Brien, indicating a wish to support his colleague rather than challenge him.[299] Along with others, he raised concerns about missing clinic letters and documentation, which impacted patient care and clinic efficiency.

374. More is said about Mr Young's role as CL of the service elsewhere in this Report, but the Inquiry is of the view that part of the role involved escalating matters through the medical line management route when an informal approach was ineffective. Mr Young clearly did not recognise at that time that he ought to have done so, although when giving evidence to the Inquiry he discussed some incidents when he should have submitted IR1s but did not.[300] This is not only a failing on his part but also of the training provided for roles in medical leadership.

375. Mr Glackin was a friend of the O'Brien family. He described Mr O'Brien and Mr Young as his mentors. He described Mr O'Brien as a safe operator who provided thorough assessments and detailed handovers. He was aware, however, of the lack of dictation by Mr O'Brien from when he first started in Craigavon in 2014.[301] He described how Mr O'Brien's practices could affect patient safety.[302] He told the Inquiry that he never raised any concerns formally:

> "I certainly never did an IR1, as far as I know. Whether we had informal discussions about the timeliness of correspondence, I'm sure we did. That would have been the kind of thing that would have been, and it was discussed at departmental meetings, the need for letter writing and notes to be in the chart. So those things were discussed in an open forum amongst the team. So other than those things, I don't think there was anything else.
> I don't recall having concerns about his operative capacity. I don't recall having concerns about his manner of working with colleagues and interpersonal difficulties. Certainly I didn't have any interpersonal difficulties with him.

299 TRA-09595 to TRA-09598
300 TRA-09771 to TRA-09773
301 TRA-08573 to TRA-08574
302 TRA-08826 to TRA-08828

I think it's important to reflect though that, you know, there was a definite chilling process that happened around the time of this late 2016 and returning to work in 2017. That was difficult for everybody."[303]

376. It was Mr Glackin who suggested that the team could have better supported Mr O'Brien if medical managers had shared information about his return-to-work plan when the MHPS investigation started. This would have allowed earlier identification of performance dips.[304] Issues like delayed correspondence and lack of documentation were discussed in departmental meetings. He confirmed that these were seen as patient safety concerns by the team.

377. He told us that Mr O'Brien and others did not attend departmental meetings regularly which hindered consensus building and service improvement.[305] He did not raise formal complaints but acknowledged the difficulties in communication and governance around Mr O'Brien's practice.[306]

378. The wider team was also impacted by Mr O'Brien's failure to complete triage at the time of his exclusion, having to urgently deal with those cases that were untriaged by him. It is clear from Mr Glackin's evidence that there was a lack of full, open, face to face discussion with the team from medical leaders at this time.

379. Mr O'Donoghue followed Mr O'Brien as UoW and found cases untriaged which he personally dealt with to ensure patient safety; this added to his own workload. He stated with hindsight he ought to have made a formal complaint given the patient safety implications.[307] As an Inquiry we agree with this concession.

380. Mr Tyson joined as a Consultant from February to July 2019 having been a registrar in the Trust previously. He was in New Zealand from 2019 to 2021 on a fellowship. During his time as a registrar and consultant, Mr Tyson stated he was

303 TRA-08770, lines 5-25
304 TRA-08768 to TRA-08769
305 WIT-42307, paragraph 31.2
306 WIT-42307; WIT-42327
307 TRA-08584

not aware of any concerns regarding Mr O'Brien's practice. Mr Young was his line manager although Mr O'Brien was involved in training registrars, including himself.[308] He only became aware of issues through the Inquiry and media reports. He expressed surprise and concern upon learning about the allegations and governance issues.

381. Mr O'Brien himself felt overwhelmed and could not complete his administrative tasks. His submission to the Inquiry was that he was compelled:

> "to make decisions in terms of what aspects of his practice should be prioritised"[309]

as a result of the demand/capacity mismatch. He took on additional surgical work, choosing to prioritise this over administration. There was apparently no insight into the impact on patient safety of his actions. As rightly observed by Dr Chada, this lack of insight is cause for concern.[310] Job planning discussions should include an agreement that any additional work can only be performed where there is no risk to patient safety. This is discussed more fully in the Medical Management and Leadership chapter.

382. Mr O'Brien's behaviour also indicated a lack of respect for colleagues, including medical colleagues who attempt to ensure that procedures are followed. He demonstrated an inability to participate in teamwork in a way that prioritised safe care. Failure to work effectively in a team is in itself a risk to patient safety.

383. This was seen in his refusal to agree a method of triaging with his colleagues without direction from the Trust and a refusal to adapt his practices. Much of his lack of compliance is not actively reported. Failing to write a letter after a consultation displayed disrespect towards the patient and the GP. It appears to the Inquiry that Mr O'Brien determined what was important and if he disagreed

308 TRA-08888
309 SUB-00206, paragraph 72
310 TRA-04146 to TRA-04147; See also MHPS chapter, paragraphs 317 and 320

with priorities and rules set, he just did not follow them. Overall Mr O'Brien displayed a lack of understanding and respect for the management and governance structures in place at the Trust.

384. The overwhelming impression given by the clinicians to the Inquiry was of a team under enormous pressure due to the demand/capacity gap and who strove to do their jobs in difficult circumstances. There were pressures operationally to meet performance targets. Cancer Services' oversight was only directed towards those targets and even then was insufficient.

385. Clinicians were trying to make progress but the overall strategic blueprint for the team was not clear and the Trust failed to involve the team in such planning. The Inquiry saw no evidence of team job planning and individual job planning was not used effectively.

386. There was insufficient investment in governance functions to support audit. There was no real focus on the development of medical leadership roles for the CL and no defined path for progression into CD, Assistant Medical Director and MD roles.

387. Moreover, the prevailing culture at the Trust allowed idiosyncratic behaviour to go unchecked. The medical leadership and management systems were not robust enough to ensure effective 'normal' medical management which should ensure action on concerns in an agreed way. The information systems and governance structures did not supply enough regular clear objective information to signal deviations from standards, whether they were administrative or more directly related to patient safety and quality.

388. The Inquiry heard that the team dynamic was at times strained. Prior to Mr O'Brien's departure, the environment was described as "combative and unfriendly", particularly in relation to learning and governance.[311] Since the Inquiry began, while its work brought stress to the team, clinicians noted a shift to a more open, transparent, and collegiate atmosphere.

311 See evidence of Mr Glackin at TRA-08235, lines 3-4

Professor Roger Kirby

389. The Inquiry also heard from Professor Kirby who was engaged by Mr O'Brien. Professor Kirby is a well-respected expert in the field of urology practice with a special interest in prostate cancer. He has contributed widely to the advancement of knowledge in this area through research and training. The Inquiry received evidence from Professor Kirby, both written and oral. The written evidence from Professor Kirby related to the individual treatment in the nine SAI cases. In his oral evidence Professor Kirby was asked about Mr O'Brien's practice generally. In preparation for his oral evidence the Inquiry provided Professor Kirby with a large bundle of information regarding the MHPS investigation, Mr O'Brien's response to that investigation, together with relevant correspondence and statements. The Inquiry found Professor Kirby's perspective on Mr O'Brien's practice useful.

390. In his reports on the nine SAI patients Professor Kirby told us that he did not intend to criticise but rather:

> "to understand why he'd [Mr O'Brien] done the things he did in regard to those nine patients".[312]

In seeking to understand Mr O'Brien's behaviour Professor Kirby acknowledged the skills and contribution Mr O'Brien had made to the Trust's urology service. He commented on his contribution to training and research and the establishment of the CURE charity, as well as his commitment to the service. He also noted the difficult environment in which Mr O'Brien worked stating that:

> "In all the nine cases I'm defending Mr. O'Brien because I think he did his best. His best might not have been the best available in the world for these patients but he was doing his utmost best."[313]

312 TRA-09343, lines 3-4
313 TRA-09397, lines 15-18

391. Professor Kirby formed an opinion that Mr O'Brien was "trying to be kind" by prescribing what might be described as "a gentler form of therapy" in referring to Mr O'Brien's use of Bicalutamide as a monotherapy.[314]

392. Although Professor Kirby defended many aspects of Mr O'Brien's practice, he also described the practice as being 'not ideal' or 'idiosyncratic' in a number of respects. Professor Kirby when questioned by Inquiry Counsel, gave his view on a number of matters.

393. Many of these areas align with the findings of the Inquiry and although the emphasis in his evidence was much less critical than that of other experts such as Dr Hughes and Mr Gilbert, he effectively agreed that best practice was not followed in many areas and also made the comment that the Trust's urology team was dysfunctional:

> "I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet because it is so difficult. Some people are very difficult to deal with, especially senior surgeons perhaps."[315]

394. In summary Professor Kirby:

- Described Mr O'Brien as a kind and caring clinician who was clearly trying to help his patients and was motivated by kindness, particularly in his preference for gentler treatments like Bicalutamide.
- He noted that Mr O'Brien seemed to form strong bonds with his patients and that they trusted him, suggesting he was a good communicator.[316]
- He acknowledged Mr O'Brien's surgical skill, particularly in open surgery, which he described as becoming rare due to the rise of robotic techniques. He

314 TRA-09370, lines 15-16
315 TRA-09462, lines 17-23
316 TRA-09409

praised Mr O'Brien's handling of a difficult nephrectomy in an elderly patient, calling it a good example of his surgical proficiency.[317]

- He mentioned that Mr O'Brien had helped train other urologists.
- He acknowledged Mr O'Brien's role in founding the CURE charity and his contributions to research and academic urology.
- He repeatedly stated that while Mr O'Brien's methods were not always ideal, he believed Mr O'Brien was doing his best under difficult circumstances.

395. Nonetheless, Professor Kirby did tell the Inquiry that Mr O'Brien was not a mainstream urologist and had an unusual, idiosyncratic approach to his clinical work.[318] He noted that Mr O'Brien preferred to work alone rather than collaboratively with colleagues or managers.[319]

396. In respect of CNSs Professor Kirby agreed with Inquiry Counsel that a nurse might assist in the avoidance of patient risk:

> "The key point, really, is the nurse should provide a point of contact. Often it's extremely difficult for a patient to speak to his overarching clinician on the telephone, or send an email. …
> I'm not sure why Mr. O'Brien didn't avail himself of the help of one of those -- of all five Clinical Nurse Specialists. I think it's his practice, he decided not to. I don't think he actively stopped them but he didn't actively encourage them either."[320]

He told the Inquiry that:

> "I think Mr. O'Brien obviously preferred to work, you know, more in isolation than perhaps was ideal and he didn't employ the help of the specialist nurses

317 TRA-09383 to TRA-09384
318 TRA-09348
319 TRA-09348 to TRA-09349
320 TRA-09382, lines 9-26

quite as well as he might have done. I think it would have helped the patients. It would have helped him, actually." [321]

397. He pointed out that Mr O'Brien was reluctant to delegate care or adapt to modern multidisciplinary practices. He accepted that Mr O'Brien's tendency to retain full ownership of patients was, as Counsel put it, "a bit of a blind spot", especially in the context of modern team-based care.[322]

398. Professor Kirby observed that:

> "I can see that Mr. O'Brien did get into conflict with the management of the Trust. I think a lot of his energies were devoted to those sort of struggles with them and probably that was, you know, of emotional detriment to him and possibly affected the way that he managed his practice."[323]

399. In discussing cases where Mr O'Brien failed to refer patients back to the MDT when treatment plans changed or complications arose, he stated that:

> "I think if there's a major change, then it probably should be brought back, but I don't think it is a necessary stipulation that happens in every case."[324]

He conceded that in the case of Patient 1:

> "I think in this specific case, as you say, it is quite a major departure from the recommendation. So yes, another urologist probably would have brought that back. Mr. O'Brien, I think, likes to do things his own way so he chose not to."[325]

321 TRA-09352, lines 4-9
322 TRA-09353, line 11
323 TRA-09354, lines 15-21
324 TRA-09360, line 28 to TRA-09361, line 1
325 TRA-09365, lines 24-28

400. He described Mr O'Brien's frequent use of 50mg Bicalutamide as a "gentler form of castration therapy,"[326] as "a less than ideal treatment",[327] and stated that:

> "I wouldn't have used 50mg unless I was forced into that position by a patient saying I want to preserve my potency, I'm getting bad side-effects from 150mg so give me a lower dose."[328]

He also stated that:

> "I think we can see that Mr. O'Brien has a preference for the use of Bicalutamide, at an admittedly suboptimal dose, and a reticence to refer patients for radiotherapy."[329]

401. While noting that MDT advice/recommendation was not mandatory, where there was a departure from that recommendation it should be recorded along with a plan of management.[330]

402. In respect of delay or failure to act on important scan results, which posed risks to patient safety, Professor Kirby agreed with Inquiry Counsel that:

> "Q. primarily the responsibility rests with the doctor to get it done promptly?
> A. Yes. If you order a scan and then you're unaware of the results and the results show something sinister and you missed that, then you're the one responsible really."[331]

403. Professor Kirby was critical of the long delays – sometimes weeks or months – in dictating clinic letters, which hindered communication and continuity of care.[332] He stated:

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326 TRA-09370, line 10
327 TRA-09408, lines 11-12
328 TRA-09409, lines 14-17
329 TRA-09416, lines 23-26
330 TRA-09371
331 TRA-09425, line 24 to TRA-09426, line 1
332 TRA-09376

> "I think, again from looking more widely, it is clear that Mr. O'Brien's practice of dictating after clinics was less than ideal. Most urologists do dictate immediately, either at the time of the clinic -- although that slows the clinic down considerably -- but at least within 24 hours or so. It is hard to remember all the details of the case and you want to have recorded everything. If you dictate immediately after a clinic or the following day, then you can remember the facets of the case. If you leave it, as Mr. O'Brien has tended to do, for sometimes weeks, even months, then you're entirely relying on what you've written down and you can run into problems and delays. …
> I think his practice was deficient in the speed, the celerity with which he dictated after seeing patients in the clinic and this is an example of that."[333]

404. He agreed that the practice of keeping patient records at home was to be discouraged.[334]

405. He noted that Mr O'Brien failed to triage hundreds of referrals, including red flag cases, which led to delays in diagnosis and treatment. He stated:

> "I think Mr. O'Brien got in a bit of a muddle, he wanted to do advanced triage whereby he looked at the letter and tried to decide which investigation to do on the basis of the letter rather than seeing the patient and having more information. I think that risked doing the wrong investigation -- wasting time doing investigations that weren't really necessary. Then not really paying attention to the ones that he thought were routine and storing them away in his desk drawer and getting behind on his administration with those, which was obviously not good."[335]

406. Professor Kirby emphasised the importance of conducting proper preoperative assessments, including in a case where a patient died post-surgery:

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333 TRA-09376, lines 2-22
334 TRA-09440
335 TRA-09436, lines 19-29

> "It is critical to perform a preoperative assessment for Patient Safety reasons, number one; for administrative reasons, number two. [sic] If you bring patients in for surgery either the night before or often these days on the day of surgery, and then you find that you can't operate because they haven't stopped their blood-thinning tablet or they've got some other kind of problem, then you lose a slot on the operating list and the waiting list gets longer and longer. …
> If you are dealing in urology with elderly patients and overweight patients, etcetera, diabetic patients, then it's particularly important for Patient Safety reasons that you do that. They often have comorbidities, particularly cardiovascular comorbidities, which would be another reason not to go ahead and operate."[336]

407. Professor Kirby was asked about the opinion he formed of Mr O'Brien:

> "Q. Clearly in the 2,000 or so pages that you've read and your conversation with a colleague, you formed an opinion of Mr. O'Brien. I just wonder if you would share some of these views; that he was someone who worked in isolation rather than as a team player?
> A. Yes, I think he obviously did. To his detriment, I think, to the patient's detriment. He didn't seem to want to collaborate with his colleagues as well as he should have done, especially the radiotherapists in Belfast. That would have been -- a close relationship would have been ideal. And he had his own way of doing things and perhaps was reluctant to change."[337]

408. In summary, Professor Kirby concluded that Mr O'Brien worked in isolation, was not a team player, and failed to adapt to evolving standards in clinical governance and multidisciplinary care.[338] He thought him an "old-fashioned" clinician who has

336 TRA-09446, line 9 to TRA-09447, line 2
337 TRA 09467, line 27 to TRA-09468, line 9
338 TRA-09468

found it difficult to adapt to a changing landscape of the way that medicine is practiced.[339]

409. This assessment accords with the Inquiry's view of all that we heard and saw relating to Mr O'Brien's practice.

Mr O'Brien's response to criticisms

410. Mr O'Brien disputed a number of the statements made about him by Professor Kirby and others and offered explanations for many of the criticisms levelled at him.

411. In relation to the description of himself as 'old-fashioned' when asked by Mr Wolfe:

> "Q. So the description of you as an old-fashioned practitioner and whatever that necessarily conveys, it doesn't sit easily with you?
> A. I mean, old-fashioned can mean experienced; old-fashioned can mean having accumulated a great deal of wisdom and insight along the way.
> Q. He defined it, just to be clear, as showing an inability or a difficulty in adapting to a changing medical landscape?
> A. Well, it depends on what the -- the adaptation precisely is. But I don't recognise the generality at all."[340]

412. Mr O'Brien also rejected comments made by Professor Kirby relating to his perception that Mr O'Brien did not fully understand the benefits of collaboration with a wider clinical team.[341]

413. Mr O'Brien failed to acknowledge the impact on patient safety of not following cancer guidelines, instead he chose to offer justification for each decision where

339 TRA-09439, line 11
340 TRA-12519, lines 8-19
341 TRA-12549 to TRA-12551

possible. He was a senior clinician who worked during a time when there were many developments in cancer care and treatment. These included the development of cancer guidelines and standards and he was well aware of these, having chaired the regional cancer group for urology, been the lead for implementation of the Cancer Peer Review Standards for Urology at the Trust and been the Chair of the Trust's Urology MDT. He disagreed with the suggestion that he did not follow guidelines. When asked by Inquiry Counsel whether guidelines affected in any way his management of prostate cancer he stated:

> "A. Of course.
> Q. In what particular ways?
> A. In every way. I mean, they are the guidelines. They are the accumulated recommendations for prostate cancer in its differing stages, the options, the benefits, the risks, do you know, they are -- I don't think any clinician should be practising at all without being cognisant of the guidelines and having the guidelines influence their management. But the guidelines – you know, I've heard some people saying, you know, they require adherence, but, in fact, actually, the guidelines themselves are prefaced with the direction that they do not require adherence. If they required adherence, they wouldn't be called guidelines."[342]

414. Mr O'Brien had a lengthy discussion with Inquiry Counsel regarding the deviation from guidelines in respect of Bicalutamide prescription. It appeared to the Inquiry that while he seemed to support the development of guidelines, nevertheless he felt his personal experience and ability to discuss options with his patients allowed him to unilaterally decide not to follow them. Throughout his evidence Mr O'Brien's reason for failing to implement MDT recommendations seemed to boil down to what he saw as an overarching duty to his patients. He gave the example of Patient 1 to illustrate this, explaining that he sought to reduce cardiovascular complications of hormone therapy by using a lower dose of Bicalutamide.[343] He told us that he often needed to use a different approach to

342 TRA-12579, lines 8-21
343 TRA-12573 to TRA-12574

that advocated by the MDT because it was better for the individual patient, largely because he considered the side effects would be reduced but also because he considered that prolonged hormone treatment to reduce levels of PSA would lead to treatment with radiotherapy being more effective in the long run. He commonly prescribed prolonged hormone therapy (Bicalutamide 50mg) prior to referral to oncology. There is no evidence that he discussed his rationale for doing so with his colleagues or that he informed patients that the treatment was outside of guidelines. One key impact of this was that the patients were not referred to the oncology team to discuss the timing and type of further definitive treatment in a timely way and sometimes not for some years. The Inquiry is of the view that Mr O'Brien's approach potentially overplayed the risks of certain treatments, such as radiotherapy and risked the undertreatment of potentially lethal cancer.

415. Mr O'Brien was clearly aware of and supported the need for functioning urology MDT meetings and understood the importance of specialist input from oncology, radiology, pathology and CNSs. He was aware of the need for standard policies for the operation of MDTs and for the need to allocate a CNS to act as a key worker. He was clearly also aware of other important standards advocated in Peer Review including providing patient information regarding the MDT and the MDM process as well as suitable written information regarding the decisions made. The MDM discussion for individual patients would have included recommending treatment protocols in line with the guidelines mentioned above, as well as inviting comment from, for example, CNSs who might be able to offer insights into a patient's specific social or personal situation. Nonetheless, from the evidence the Inquiry has seen relating to the SAIs and other cases, in his own practice he departed from standards that were set out.

416. Mr O'Brien failed to systematically escalate the many gaps in peer review standards in a way that highlighted the importance of this to senior people in the Trust. In fact, the assurances given in the Peer Review document,[344] which he

344 TRU-84684 to TRU-84691

produced, were not real. A particular gap related to the availability of a CNS in cancer for each patient. More is said about this at paragraphs 234 to 259 above.

417. This was compounded by the fact that the Trust's Cancer Services had not considered or developed an internal governance review process for continually updating and challenging compliance with peer review standards for cancer. However, having been a central figure as chair of the NICaN urology division when the standards were set down, Mr O'Brien would have been aware of the gaps in compliance. In his role he had a duty to highlight these in a way that focused on the risks to patients. Although he recognised the lack of quoracy as an issue particularly for radiology he should have done more to ensure more rapid progress towards full quoracy to include oncology. He also failed to highlight the consequences of an inadequate provision of CNSs to act as key workers for cancer patients in urology.

418. In his own cancer practice Mr O'Brien failed to follow some of the central principles of the national cancer standards which included the allocation of a CNS and the provision of a written summary of the treatment plan for the patient. Neither did he record the information given to the patient. In the nine SAIs none of the patients had been given access to a key worker and none knew about the MDT process, indicating that he had failed to inform patients in the way intended. He also did not inform the MDT of the change of treatment or bring those patient discussions back to the MDT.

419. In relation to MDT recommendations Mr O'Brien told the Inquiry:

> "I think when you look at the language of various documents, including the one on the screen in front of us, there is -- there is a -- there is room, I think, for differing interpretations of the rigidity, or the obligations that are placed upon the patient and the clinician in charge of that patient with regard to implementing, as you said -- you referred to it as implementing the MDM recommendation. The clinician actually implements the MDM recommendation by ensuring that the patient is informed of the MDM recommendation. There's

a major dichotomy here: Is it the case that the MDT in the vehicle of the MDM is actually deciding how this patient is to be managed, and that you bring that recommendation to the patient with a degree of obligation that is not entirely respectful of the patient's own autonomy, and which we can get on to at a later date with regard to, and particularly with regard to prostate cancer, the whole reality of management decision regret? So, is it, as Dr. Hughes indicated, that the MDT is actually treating and managing the patient? Or is an MDT that formal structure, which I had every faith in, and which I participated in so much, and which I valued so highly, in actually arriving at, with the best knowledge that it had at that moment in time, how this particular pathology should be managed? And it is the clinician's responsibility to bring that to the patient, and did we have a practice where there's a divergence from that recommendation to bring it back? We didn't have that. I would have had no problem with doing so, except for the fact, actually, that it would have overwhelmed an MDM that, as you know, was already deficient."[345]

420. The Inquiry considers that this was more than an occasional oversight of a busy doctor. It conveys the impression that Mr O'Brien believed that due to his extensive experience and his style in terms of interactions with patients he had no need to follow these guidelines or rules. Certainly, he did not consider that there was a need to explain or justify deviations to others, and he was convinced that he always explained everything fully to patients and did not need to confirm those discussions in writing.[346]

421. Further, it is the Inquiry's view that Mr O'Brien failed to acknowledge the impact on patient safety of not adhering to MDT guidelines. His failure to adhere to the treatments recommended by the MDT is an extension of his attitude to the overall cancer standards where there appeared to be a belief that the MDT view was in some sense an opinion that could be overturned without justification, explanation or documentation. While Mr O'Brien was clearly an active participant in MDMs

345 TRA-12535, line 8 to TRA-12536, line 11
346 TRA-12650, line 18 to TRA-12651, line 15

and the recommendations were recorded via the MDT these recommendations did not necessarily feature in the subsequent treatments prescribed.

422. The evidence that the Inquiry has seen and heard does not convey adequately what recommendations were communicated to the patient or what discussions resulted in the change in treatment prescribed. This was particularly evident from those patients and family members who gave oral evidence. The failure to have the back up of a CNS to assist the patient and witness the discussion added to the risks posed by the deviation from recommendations.

423. There were a few common patterns in the deviations from MDT recommended treatments. One related to the prescription of Bicalutamide 50mg which was not done in an evidenced based acceptable way and deviated from best practice guidance. The other was the prescription of Bicalutamide 150mg as opposed to more modern androgen suppressants and the third was failure to refer for an oncology opinion in a timely way or sometimes at all.

424. Although Mr O'Brien had a rationale for this behaviour, he failed to have any insight regarding the fact that this was at odds with the whole principle of MDT working. He also refused to acknowledge that uniprofessional care might not be in the best interests of patients. All of this goes against the spirit of good medical practice in terms of prioritising patient safety and working with colleagues using best evidence to achieve what is best for the patient.

425. The full extent of the problems with Mr O'Brien's practice were not appreciated due to the problems with governance, assurance, leadership and the prevailing culture of the Trust referred to elsewhere in this Report.[347] This meant that there was no awareness that cancer standards as set out through Peer Review were not being met or that individuals were not complying with these. This was made worse by the lack of full development of MDM processes and longer term plans

347 See Governance and Medical Management and Leadership chapters

led by cancer services. The Trust did not have any systems to regularly audit adherence to guidelines.

426. As there was no audit of compliance with MDM outcomes these matters were not picked up until the time of the Inquiry, although there was some knowledge of the prescribing of Bicalutamide 50mg which was brought to Mr O'Brien's attention to no avail.[348]

427. In respect of a clinician's responsibility to dictate after each clinic. Mr O'Brien told us that he was unaware of any Trust policy requiring him to do so.[349] Mr Glackin told the Inquiry that the matter had been discussed at a departmental meeting and:

> "Mr. O'Brien perversely expressed the view, perversely from my perspective, the view that it wasn't necessary to dictate on every patient, that he knew what was going on and he didn't have to write to the GP."[350]

428. Mr O'Brien, in his witness statement said:

> "The use of the consultation for this purpose should not be compromised, or displaced, by the dictation of a letter to the GP. Important as that letter is to the GP, and to others, it is of secondary importance at that time. Indeed, the irony is that displacement of consultation time by dictating the letter to the GP has rendered the letter to the GP all the more important, as there is an increased likelihood that the patient may then have to consult with their GP to obtain more information, which might have been given to the patient by the hospital doctor if the consultation time had been fully used to do that. This is an example of process or protocol displacing the purpose.
>
> It has not been my experience that my patients have had to consult their GP to gain further information or insight following consultation with me, though I

348 See in particular the evidence of Dr Mitchell at WIT-96670; TRA-07820 to TRA-07821
349 TRA-04741
350 TRA-08775, lines 25-29

do appreciate that I may have been the last to know. My experience has been to the contrary, but it has taken time, and that time has usually been my own, as sufficient time was never allocated to me."[351]

Conclusions

429. The Inquiry is cognisant of the history of the urology service in the Trust, mindful of Mr O'Brien's contribution to that service and the conditions caused by an increasing demand for that service under which Mr O'Brien, his fellow clinicians and the wider team had to operate. Further, the Inquiry accepts that Mr O'Brien and others raised issues regarding the inadequacy of this service, the difficulties for clinicians and the risks to patients for many years. The Inquiry is also aware of the challenging issues for our health service in a situation of ongoing financial constraint.

430. It is in that context that we have had to assess all the evidence that we have read and heard. The Inquiry completely accepts that Mr O'Brien believes that the urology service was, as his Counsel Mr Boyle put it in his oral closing submission: "seriously and significantly under-resourced for over three decades".[352] Mr O'Brien in his submission to us sees the matter in very black and white terms:

> "From the inception of the Trust's urology service until Mr O'Brien's employment ended in July 2020, the Department of Health ('the Department'), the Health & Social Care Board, Craigavon Area Hospital Group Trust and the Southern Health and Social Care Trust have presided over a grossly inadequate and unsafe urology service, causing patients to suffer and come to harm. It was disheartening in the extreme to hear from the Department's permanent secretary, Mr May that, if anything, the situation will continue to deteriorate before there might be some improvement in urology services provision."[353]

351 WIT-82572, paragraphs 506 and 507
352 TRA-12706, lines 23-24
353 SUB-00187, paragraph 9

431. This fails to have regard to the evidence that the Inquiry heard about the difficulties the Trust had in both recruitment and retention of staff. The message from the evidence was that staff prefer to work and live in Belfast. More is said about this elsewhere in this Report. The Inquiry is satisfied that many services in the Trust, the region and nationally have struggled in the past decades due to resourcing issues. Urology in Craigavon is not an outlier in that regard.

432. The Inquiry accepts that this Trust, like others, focused on ministerial targets over the quality of care provided. There can be no doubt that the situation was difficult for Mr O'Brien initially and then Mr Young, before the additional consultants came to work in the service. Even then, the Inquiry accepts that the service was strained.

433. It should be remembered, however that urology was not the only service in the Trust, in the region or across the nation to have to had to deal with either austerity measures or budgetary/efficiency restrictions over the years and that that context cannot excuse the failure of individuals to carry out their duties within the environment in which they had to work. It cannot be an excuse for poor practices, failing to adhere to Departmental directions, employer requirements and expectations or, perhaps most importantly, professional standards.

434. The Inquiry accepts that Mr O'Brien was dedicated to helping others and that he does not fall into a category of malicious clinicians identified in other inquiries. The Inquiry accepts that Mr O'Brien was hard-working and highly thought of. Mrs Esther Gishkori, former Director of Acute Services was of the view that Mr O'Brien "built up" urology services in the Trust "singlehandedly."[354] Mr O'Brien was a sole consultant for four years, until the appointment of Mr Baluch in January 1996, who was replaced after a gap of four to five months by Mr Young in May 1998.

354 TRU-263681 to TRU-263682

435. Many of those who gave evidence to the Inquiry, held Mr O'Brien and his skills as a surgeon in high regard. In his statement to the Inquiry Mr Mackle said:

> "Whatever else one may say about Aidan O'Brien, no one can say that he wasn't hard working and committed to his patients. He was certainly not the first to arrive in the morning but he was among the last, if not *the* last, to leave in the evening. He was held in high regard by the majority of the staff in the hospital including porters, other ancillary staff, nurses, doctors and his Clinical Director."[355]

436. There can be no doubt that many patients benefited from the service he provided to them over the years, the former Chair of the Trust's Board Mrs Roberta Brownlee being the most notable example.

437. Mr Brown in an email to Ms Trouton sent in November 2013 stated:

> "Aidan is an excellent surgeon and I'd be more than happy to be his patient".[356]

438. The Inquiry is of the view, however, that Mr O'Brien was inefficient in his practices thereby adding to the burden of others and putting patients at risk.

439. Having been the sole practitioner in the service, Mr O'Brien was able to work as he wished and without any peer challenge, moreover as a senior consultant responsible for the service there was a degree of reverence and deference afforded to him that was inappropriate. He was enabled to practice as he wished because should his practices be questioned the response was 'that's just Aidan' or similar and he was not challenged. Indeed, if anyone sought to challenge him, they had to be prepared, as Mr Young put it, to argue their corner. He was as Mr Haynes described "a challenge to challenge."[357]

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355 WIT-14772, paragraph 19
356 WIT-98423
357 TRA-00842, lines 1-2

440. Mr O'Brien's view was that if directed to do something by the Trust that he and his colleagues agreed with, he would do so. With regard to triage Mr O'Brien told the Inquiry that:

> "The fundamental issue with regard to triage was for myself, with my colleagues sitting down with, for example, the Medical Director and the Director of Acute Services, to work out exactly what it was that was required of us. That's what I wanted. That's what I asked for. That's what did not happen."[358]

441. Despite this view, the evidence seen by the Inquiry clearly demonstrated that Mr O'Brien often questioned any direction given to him and if he did not agree with it, he seemed to sometimes refuse to comply and in other cases simply ignored it and did what he wished, whenever he could do so without any consequences. Examples include his response to the directive from the MD in 2016[359] and responses to other directives such as the need to look at results and the use of the DARO system discussed earlier in this chapter. It is also clearly seen when Mr O'Brien refused to move to the use of bipolar equipment for resection because it did not accord with his preferred way of operating.

442. In October 2013 the Senior Coroner for Northern Ireland wrote to the Chief Medical Officer (CMO) regarding surgical and anaesthetic failings in connection with a gynaecological case where an operation in the Ulster Independent Clinic led to the death of a young woman. A review of the use of glycine in connection with a monopolar device was instigated, leading ultimately to the Deputy CMO on 18 August 2015, issuing a policy, making the case for changes to both urological practice as well as gynaecological practice and mandating a move from monopolar to bipolar resection. The service trialed two pieces of equipment from different manufacturers and recommended the purchase of one. That recommendation was the unanimous choice of all the consultants, including

358 TRA-12191, lines 16-21

359 See for example the response to a memo sent by Dr Wright regarding duty of care in June 2016 at TRU-278868 to TRU-278870. The Inquiry is unaware of whether Mr O'Brien did in fact comply as directed.

Mr O'Brien, who told the Inquiry that he agreed with the purchase but not with the use of the equipment.[360]

443. Despite the Trust and the Service being directed to move to bipolar resection and Mr Young telling the Inquiry:

> "I think there was the expectation that he would move like the rest of us too. I don't remember him informing us that he had not moved over."[361]

Mr O'Brien did not like using the equipment and did not make the move. He told the Inquiry:

> "I wasn't required to move over. I was certainly facilitated in continuing to use monopolar resection, using glycine, with all of the precautions that I had been used to since my training days in Dublin in the 1980s and which were further reinforced and regimented, in fact as I had experienced them back in Dublin in the 1980s, with regular biochemical analysis during resection and so forth. So, I mean, I have a long experience of resecting prostate using glycine. I have addressed that in the recent addendum, and I think the only thing I would add to that recent addendum, I did relate that the only severe case of TUR syndrome that I have ever experienced, or known of, was in Dublin; it happened to be the first I've ever experienced, and when you experience a severe TUR syndrome, you don't forget it. I remember it vividly in about 1987/'88, or thereabouts. So I've always been very vigilant with regard to biochemical derangement during resection of the prostate. I have found it to be, using monopolar with glycine, to be safe in my hands. I did give it a fair wind, even though I declared upfront that my fair wind may have been considered prejudicial, but, in my hands, I was much happier with, and for the safety of the patient in my hands, I continued to use monopolar, with glycine, and was facilitated in doing so."[362]

360 TRA-12504 to TRA-12505
361 TRA-09755, lines 1-3
362 TRA-12506, line 21 to TRA-12507, line 17

444. There was a clear directive to the Trust to implement a change but no processes were put in place to monitor the change and to ensure that all surgeons moved to give effect to the directive. Mr O'Brien chose to continue practising as he preferred with no consequences and was facilitated to do so because of the lack of audit of procedures. This was a clear governance failing.

445. The Inquiry has carefully considered Mr O'Brien's closing submissions.[363] Mr O'Brien presents an account of his skill, work ethic, commitment and reliability as a practitioner and suggests that an absence of an adequate service is the explanation for any shortcomings in his practice.[364] However, attentiveness to patients and an admirable work ethic cannot stand in the way of challenge or criticism where a practitioner otherwise decides to disregard standards and safe working practices. Moreover, Mr O'Brien's colleagues appeared to recognise that the frailties of the under-resourced service were such that it was incumbent upon them to use their skills (some might say their common sense), the support staff, and the systems of support available to them, so that they could practice as safely as possible. This meant adopting processes such as DARO (a process which Mr O'Brien rejected,[365] despite the safety net it would have provided to him) to help better manage those patients who might require a review appointment when reports became available. It also meant triaging patients using a methodology which was consistent with enabling professional engagement with all of the referrals rather than just a few. It might have involved delegating appropriately to members of the administrative team or junior clinicians.

446. At the commencement of the Inquiry Mr O'Brien and the other core participants were invited to use the process as an opportunity for reflection and to offer up insights into how he and others could have performed better. The Inquiry's ToR place a central focus on the Trust's governance arrangements and response, but they nevertheless direct attention towards Mr O'Brien's behaviours as a vehicle

363 SUB-00185 to SUB-00232
364 SUB-00189 to SUB-00190, paragraphs 17-18
365 SUB-00229, paragraph 152

for examining the adequacy of the governance framework. The Inquiry considers that Mr O'Brien's closing submissions and the written response to the Chair's submission reflect a continuing failure of insight.

447. In respect of Mr O'Brien's practice the Inquiry has concluded that:

- He had a practice of using several days of antibiotic IV for patients as an inpatient which in his view prevented or ameliorated recurrent UTIs. As part of this regime, he also used subtherapeutic doses of gentamicin. This was without Trust approval and absent peer review.
- He was reluctant to accept the recommendations to centralise specialist surgery and cancer work in the interests of improving overall standards.
- He repeatedly failed to perform triage.
- He failed to dictate timely letters on patients and adopted the practice of not dictating on sequential outpatient visits with a long summary letter after many months.
- He failed to follow procedures relating to private patients.
- He failed to look at radiology reports in a systematic way, risking harm to patients.
- He failed to ensure that all his cancer patients had an assigned key worker and did not sufficiently engage with the CNS or patients to make sure they had one.
- He failed to acknowledge the impact on patient safety of not following cancer guidelines.
- He failed to acknowledge the impact on patient safety of not adhering to MDT guidelines.
- He failed to understand the Trust's systems of governance and failed to raise his own lack of ability to triage as a safety issue.
- He prioritised work according to his own priorities whilst not adhering to Trust guidelines and policies.
- He engaged in excessive reviews of patients thereby depriving other patients of clinical time.

- He kept large numbers of patient records at home thus breaching information governance guidelines and risking patient safety through lack of availability of patient records on the hospital site.
- He failed to bring adequate information regarding audit to appraisal, failed to reflect on serious issues during the appraisal and failed to bring any information to appraisal regarding his private practice. This is discussed further in the Medical Management and Leadership chapter.
- He failed to realise that he needed to work as part of a team or appreciate the pressures that he placed on his clinical colleagues due to his administrative and clinical shortcomings.[366]

448. It appears that most of the clinicians in the Urology Department worked together in a way that supported the standards required by professional bodies, however, this has not been subjected to audit. The overall focus on adherence to standards and prioritisation of patient safety was lacking. This was no conscious omission but rather was related to the prominence of financial and operational pressures. The Trust missed opportunities to act and intervene effectively after serious incidents and failed to intervene effectively and consistently when there was deviation from agreed ways of working.

449. Further, the Inquiry has concluded that there was sufficient information available to the Trust to indicate that Mr O'Brien was a doctor in difficulty but management took no steps to address his difficulties until the MHPS investigation and that investigation in itself ought to have prompted a deeper investigation into his practice.

450. While these were undoubtedly the shortcomings in Mr O'Brien's practice, and he bears responsibility for those shortcomings and professional failings, he was never properly challenged about his practices. The Trust did not have adequate systems of governance to highlight and escalate those shortcomings. Nor did his employer put in place the systems and processes to support him in delivering a

366 See also MHPS and Governance chapters

safe practice. This reflects a failure to develop and sustain not only the governance structures but also the cultural and professional environment required to assure patient safety. If patient safety is to be properly prioritised then the cultural and operational systems need to ensure that they actively enable clinicians to give of their best. Systems must mandate that deviation from agreed standards is measured, reported back to clinicians and requires explanation. This is in keeping with work on just cultures and human factors in patient safety.

451. More is said about medical leadership and leadership from the Trust Board in the Governance and Medical Management and Leadership chapters. The Inquiry is satisfied that there was a lack of unifying focus on patient safety issues from the Board. There were uncertain strategic plans and a lack of involvement of clinicians in ongoing planning. This requires to be addressed.